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Supreme Court, U.S.
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In The

Supreme Court of the United States

October Term, 1998

WOLFGANG SCHUG, M.D.,

Petitioner,

vs.

DAVID BURROWS, successor-in-interest to Cody Burrows, deceased; DAVID BURROWS and RHODA THOMAS individually and as heirs and surviving parents of Cody Burrows,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. This case raises the following question of first impression for this Court as to which there is not uniformity among the circuits:

   - **Should this Court recognize a medical peer review privilege through the application of federal common law or comity in deference to the privilege recognized by all 50 states and the District of Columbia?**

2. This case raises a question specifically left open by this Court in *Jaffee v. Redmond*, 518 U.S. 1, 15 n.15 (1996):

   - **Is a defendant in a federal question case against whom only state claims are asserted protected by state evidentiary privileges under Federal Rule of Evidence 501?**

3. Finally, this case raises a procedural and jurisdictional question as to which there is conflict among the circuits:

   - **May a party who would be irreparably harmed by a loss of confidentiality take an interlocutory appeal to challenge a discovery order directing another party to disclose privileged materials?**

LIST OF PARTIES

In addition to the parties listed in the caption of the case on the cover, Redbud Community Hospital and Adventist Health, Inc. will be filing a separate petition for certiorari.

Janzen, Johnston & Rockwell Medical Management Services Group, Dr. Schug's medical group, is a party to the underlying action but not to the appellate proceedings under review, and was just granted summary judgment.

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PETITION FOR WRIT OF CERTIORARI

Petitioner Wolfgang Schug, M.D., respectfully prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Ninth Circuit in this case.

OPINIONS BELOW

The order of the United States District Court for the Northern District of California refusing to recognize the existence of a peer review privilege protecting physicians and hospitals as a matter of federal law, federal-state comity, or state law pursuant to Federal Rule of Evidence 501 is found at Appendix D. The Court declined to change its ruling on rehearing. (*See* Appendix C.) The ruling on appeal and denial of writ relief by the United States Court of Appeals for the Ninth Circuit is reproduced as Appendix B. The Ninth Circuit's ruling on Dr. Schug's petition for rehearing and suggestion for rehearing *en banc* is reproduced as Appendix A. All of the opinions below are unreported.

JURISDICTION

This Court has jurisdiction under 28 U.S.C. § 1254(1). The United States Court of Appeals for the Ninth Circuit decided this case on November 16, 1998, and denied Dr. Schug's timely Petition for Rehearing on December 31, 1998. This petition, therefore, is timely under Rule 13.3 of this Court.

THE STATE PRIVILEGE STATUTE AND THE FEDERAL RULE OF EVIDENCE INVOLVED

The California statute protecting the confidentiality of medical peer review is California Evidence Code § 1157 (Appendix E), which will or will not be applicable under Federal Rule of Evidence 501, depending on the decision of this Court.

STATEMENT OF THE CASE

Petitioner Wolfgang Schug, M.D., is an emergency room physician at Redbud Community Hospital in the small rural town of Clearlake, California. In February 1996, Dr. Schug treated an infant on two occasions over three days. Dr. Schug ultimately determined that the boy would be better served at Santa Rosa Community Hospital, a larger hospital with more advanced pediatric services, which is about an hour from Clearlake. Unfortunately, the child suffered a cardiac arrest shortly after reaching Santa Rosa and died after subsequent transfer to the University of California Medical Center in San Francisco. The peer review committee at Redbud Hospital later met with Dr. Schug to evaluate his care of the patient.

Some months thereafter, the survivors filed suit in federal court against the hospital under the federal Emergency Medical Treatment and Active Labor Act

("EMTALA").[1] Petitioner Schug was permissively joined and named only in claims based on state law.[2]

During discovery, plaintiffs requested peer review records regarding Dr. Schug's care in this case from Redbud Hospital. The hospital refused, citing California Evidence Code § 1157, which prohibits the discovery of "records" and "proceedings" of "organized committees of medical . . . staffs in hospitals . . . having the responsibility of evaluation and improvement of the quality of the care rendered in the hospital." (*See* full text of § 1157 at Appendix E.)

On January 13, 1998 and again on May 5, 1998, the District Court ruled that the peer review records were discoverable. The court concluded that federal privilege law applies even to state law claims in federal question cases. (Appendices C and D.)

Because the District Court's order was not directed at him, Dr. Schug could not invite a contempt citation and take an interlocutory appeal therefrom; so he took a direct appeal to the Ninth Circuit Court of Appeals pursuant to this Court's ruling in *Perlman v. United States*, 247 U.S. 7 (1918) and also sought writ relief. On November 16, 1998, the Ninth Circuit (per Hug, C.J., Fletcher, J. and Trott, J.) summarily dismissed Dr. Schug's appeal and rejected his writ petition (Appendix B) then subsequently

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[1] 42 U.S.C. § 1395dd (1998).

[2] Dr. Schug is named in claims for medical malpractice and spoliation of evidence, the latter claim having been abolished by the California Supreme Court's recent decision in *Cedars-Sinai Med. Ctr. v. Superior Court (Bowyer)*, 18 Cal. 4th 1, 954 P.2d 511, 74 Cal.Rptr.2d 248 (1998).

denied rehearing (Appendix A). Dr. Schug brings this timely petition to review those orders.

SUMMARY OF REASONS WHY THIS PETITION SHOULD BE GRANTED

The quality of your next visit to your doctor, your sister's next surgery, the care your best friend will get in the Emergency Room if he or she has a heart attack – indeed the medical care of all Americans depends on what this Court does in this case.

Quality of medical care in this country is maintained through a system of peer review – doctors meeting as colleagues to critique their own care. Confidentiality is absolutely essential to candor; all 50 states have recognized this to be true by protecting peer review proceedings from discovery. Only the federal courts are out of step with the overwhelming public policy in favor of a medical peer review privilege.

In this case, Dr. Schug lost his right to the privilege by the mere happenstance that he was permissively joined in a federal suit against his hospital, despite the fact that he was only named in state law claims. This case, therefore, is not only a perfect vehicle to resolve the issue of whether there is a federal medical peer review privilege, but squarely presents the fact pattern anticipated by a question left open in *Jaffee v. Redmond*, 518 U.S. 1, 15 n.15 (1996), *i.e.*, what privilege law applies in mixed state and federal law actions? The case also presents an excellent vehicle for resolving the conflict among the circuits regarding the scope of the *Perlman* exception to the final

judgment rule and the right of direct appeal to enforce a privilege.

This case already has a high profile, having been the subject of inflammatory local, state and national publicity, which included a report on National Public Radio on February 3, 1998 and a story on ABC's *Prime Time Live* (March 18, 1998). The publicity was fueled by the filing of murder charges against Dr. Schug, which were subsequently summarily nonsuited for insufficient evidence. In view of the sensationalism already surrounding this case, it becomes an even better vehicle to emphasize the critical importance of maintaining peer review confidentiality regardless of the clamor.

ARGUMENT

I. THE MEDICAL PEER REVIEW PRIVILEGE AFFECTS THE QUALITY OF HEALTH CARE OF EVERY AMERICAN AND IS RECOGNIZED BY EACH OF THE 50 STATES.

Peer review is the cornerstone of quality assurance in modern medicine. Doctors are required to participate in peer review in hospitals, surgical centers, medical groups, HMOs and virtually any venue where medicine is practiced. It would be practically impossible to imagine how the quality of medical care would be monitored without active practitioner-to-practitioner peer review.

As recognized by every state, the District of Columbia and the United States Congress, the confidentiality of peer review proceedings is essential to assure open

exchange and real scrutiny. Now, depending on the circuit, federal courts may or may not protect the confidentiality of peer review. If there is a different federal standard, how should health care providers, who would otherwise rely on state privilege law, participate openly in peer review? They would never know if their words would be held in confidence or be used against them in federal litigation. Such a two-tiered system is out of step with the reason and the experience of the states and Congress, as evidenced by their statutory policies.

A. Peer Review is a Pervasive and Required Part of Health Care Delivery in Our Country.

Peer review is integrally interwoven into the fabric of modern American medicine. It is mandated by state statutes for the licensure of hospitals.[3] This mandate is in turn passed on to physicians by making participation in peer review a requirement for maintaining medical staff membership. As one commentator notes:

> Prompted by the need for open, candid evaluation of hospital procedures, nearly all hospitals in the United States have established a medical peer review system as a part of their operation. Many of these committees operate under state mandate or are required by federal law as a prerequisite to receiving funding for certain programs. In addition the Joint Commission on

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[3] *See, e.g.*, CAL. BUS. & PROF. CODE §§ 805.5, 2282 (West 1998); CAL. HEALTH & SAFETY CODE § 32128 (West 1998); CAL. CODE REGS. tit. 22, § 70703 (1998); 210 ILL. COMP. STAT. 85/10 (West 1998); IND. CODE ANN. § 16-21-2-7 (Michie 1998); OR. REV. STAT. § 441.055 (1998); MD. CODE ANN., HEALTH-GEN. § 19-319 (1998).

> Accreditation of Hospitals requires as a condition of accreditation that hospitals maintain a system of medical review evaluation of hospital operations.[4]

With the expansion of managed care, similar peer review guidelines have been set forth for accreditation of HMOs and other health plans by the National Committee for Quality Assurance. County, state and specialty medical societies also engage in peer review, and most state medical licensure boards rely to some degree on peer review evaluations. Thus, peer review is a required and pervasive institution found throughout our health care delivery system.

B. Confidentiality is Essential for the Functioning of Peer Review.

Courts and commentators have recognized that confidentiality is necessary for effective peer review. "As the system of peer review took hold among hospitals, the medical community realized that effective, scrupulous, and candid evaluations of the quality of medical care would be difficult, if not impossible, if peer review committee members were faced with the constant threat of pre-trial discovery in medical malpractice suits."[5] Historically, physicians have been reluctant to participate in peer

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[4] Charles David Creech, Comment, *The Medical Review Committee Privilege: A Jurisdictional Survey*, 67 N.C. L. Rev. 179, 179-180 (1988) (footnotes omitted).

[5] Sosi N. Biricik, Note, *Reconciling Section 1157, Elam, and West Covina Hospital: Is The Sanctity of the Hospital Peer Review Committee Salvageable?*, 61 S. Cal. L. Rev. 183, 187 (1987).

review for fear of loss of referrals from other doctors, accusations of defamation, and the ever present threat of becoming involved in litigation.[6] For this reason, the guarantee of confidentiality became necessary to assure the meaningful participation of physicians in peer review.

Bredice v. Doctors Hospital, Inc., 50 F.R.D. 249 (D.D.C. 1970), *aff'd*, 479 F.2d 920 (D.C. Cir. 1973) (per Corcoran, J.) was the first opinion to address the peer review privilege at the federal level, and it remains the leading case. As recognized in *Bredice*, the policies supporting the peer review confidentiality are clear:

> Confidentiality is essential to effective functioning of these [peer review] staff meetings; and these meetings are essential to the continued improvement in the care and treatment of patients. Candid and conscientious evaluation of clinical practices is a sine qua non of adequate hospital care. To subject these discussions and deliberations to the discovery process, without a showing of exceptional necessity, would result in terminating such deliberations. Constructive professional criticism cannot occur in an atmosphere of apprehension that one doctor's suggestion will be used as a denunciation of a colleague's conduct in a malpractice suit.[7]

Candid self-assessment is the primary means of ensuring a high standard of professionalism in the

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[6] Charles David Creech, Comment, *The Medical Review Committee Privilege: A Jurisdictional Survey*, 67 N.C. L. Rev. 179, 179-180 (1988).

[7] *Id.* at 250; *see also Memorial Hosp. v. Shadur*, 664 F.2d 1058, 1062 (7th Cir. 1981) (quoting *Bredice*).

medical community. Peer review, however, will not work – physicians will not engage in the sort of positive self-analysis envisioned by policymakers at every level – if it is open to discovery in federal court. The lack of confidentiality in federal courts effectively negates the confidentiality conferred on the peer review process by every state.

C. The Policy of All 50 States, the District of Columbia and the United States Congress is to Protect the Confidentiality of Peer Review.

Recognizing the vital role of peer review and the necessity of maintaining peer review confidentiality, all the states of the Union, as well as the United States Congress and the District of Columbia, have endorsed a privilege protecting the information disclosed at peer review sessions.

Congress has clearly expressed its desire to promote and protect medical peer review. To ensure access to and provision of high quality health care Congress enacted the Health Care Quality Improvement Act, 42 U.S.C. §§ 11101 *et seq.*, including provisions promoting peer review and assuring confidentiality of information required therein.[8] Key Congressional reasons for enacting this law are instructive:

> (1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems

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[8] *See, e.g.*, 42 U.S.C. §§ 11111, 11112, 11137 (1998).

> that warrant greater efforts than those that can be undertaken by any individual State. . . .
>
> (3) This nationwide problem can be remedied through effective professional peer review. . . .
>
> (5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.[9]

The public policy in favor of confidentiality in peer review has been recognized and addressed by all 50 states and the District of Columbia.[10] Every one of these jurisdictions has passed a peer review privilege statute. A chart listing these statutes appears at Appendix F. As the Court explained in *Jaffee*:

> Because state legislatures are fully aware of the need to protect the integrity of the fact finding functions of their courts, the existence of a consensus among the States indicates that "reason and experience" support recognition of the privilege. . . . [A]ny State's promise of confidentiality would have little value if the patient were aware that the privilege would not be honored in a federal court. Denial of the federal privilege therefore would frustrate the purposes of the state legislation that was enacted to foster these confidential communications.[11]

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[9] 42 U.S.C. § 11101 (1998).

[10] In addition to the states, Congress has created a medical quality assurance privilege for Veterans' Administration hospitals (38 U.S.C. § 5705 (1998)) and the Department of Defense (10 U.S.C. § 1102 (1998)).

[11] *Jaffee v. Redmond*, 518 U.S. 1, 13 (1996).

The repeated expressions of public policy in the Congressional and state statutes present a compelling reason why this Court should grant certiorari to bring all federal courts in line on this issue.[12] A decision by this Court would not only cure an unwanted disparity between state and federal law, but would also safeguard the effective monitoring of health care quality nationwide.

D. Comity Should Be Accorded State Medical Peer Review Privileges.

Comity is an aspect of the doctrine of judicial restraint whereby federal courts accede to state laws for reasons of policy or courtesy. In *Memorial Hosp. v. Shadur*, 664 F.2d 1058, 1061 (7th Cir. 1981), the Seventh Circuit explained the federal law of comity with regard to state privileges:

> A strong policy of comity between state and federal sovereignties impels federal courts to recognize state privileges where this can be accomplished at no substantial cost to federal substantive and procedural policy. And where a state holds out the expectation of protection to its citizens, they should not be disappointed by a mechanical and unnecessary application of the federal rule. (Citations and quotations omitted)

See also United States v. One Parcel of Property located at 31-33 York St. Hartford, Connecticut, 930 F.2d 139, 141 (2d Cir. 1991) ("[A]s a matter of comity federal courts accord deference to state-created privileges.").

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[12] *Id.*

Federal courts should be "very reluctant" to meddle in "sensitive state activities." *Los Angeles County Bar Association v. Eu*, 979 F.2d 697, 703 (9th Cir. 1992). Few activities are more sensitive to the states than determining the best way to ensure adequate medical care for its citizens. There is a consistent body of policy determinations regarding peer review confidentiality: every state has enacted a medical peer review privilege. These legislative determinations reflect the considered opinion of each state, after carefully balancing the interests at stake.

Reason and experience should lead this Court to recognize the states' right to determine which privileges apply to their residents. As the *Jaffee* Court stated:

> In *Funk v. United States*, 290 U.S. 371, 54 S.Ct. 212, 78 L.Ed. 369 (1933), we recognized that it is appropriate to treat a consistent body of policy determinations by state legislatures as reflecting both "reason" and "experience." *Id.*, at 376-381, 54 S.Ct., at 213-215. That rule is properly respectful of the states . . . . (*Jaffee v. Redmond, supra*, 518 U.S. 1, 13.)

The collective wisdom of the states should be properly respected in this case, as it was in *Jaffee*. Considerations of comity in this case cry out for the federal courts to yield to the interests of the states.[13] Indeed, this Court could deem the lower court's failure to accord comity to the state privilege to be such clear error as to warrant a grant of certiorari and reversal without oral argument.

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[13] Alternatively, upon granting certiorari, rather than invoking comity, the Court could fashion a federal common law privilege as it did in *Jaffee*.

At a minimum, the Court should address the divergence in the law between the federal and state governments so that those participating in the medical peer review process will know whether or not their communications are confidential.

E. Treatment of the Medical Peer Review Privilege Varies from Circuit to Circuit.

The circuit courts have not treated the medical peer review privilege uniformly. Compare:

- *United States v. Harris Methodist Fort Worth*, 970 F.2d 94, 103 (5th Cir. 1992) (citing Congressional recognition of public policy in favor of privilege but deciding not to define scope of privilege);

- *Armstrong v. Dwyer*, 155 F.3d 211, 219 (3d Cir. 1998) (peer review privilege upheld in medical malpractice case under Peer Review Improvement Act of 1982; underlying purpose of statute consistent with federal and state peer review statutes);

- *Bredice v. Doctors Hospital, Inc.*, 50 F.R.D. 249 (D. D.C. 1970), *aff'd*, 479 F.2d 920 (D.C. Cir. 1973)[14] (peer review privilege upheld in medical malpractice case);

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[14] The D.C. Circuit Court affirmed the lower court's decision without discussion. Such per curiam decisions become the law of the circuit and are binding upon the inferior courts of the circuit. (*See In re Thomas A. Cary, Inc.*, 412 F.Supp. 667, 670 (D.C. Va. 1976) (citing *Edelman v. Jordan*, 415 U.S. 651, 671 (1974), *aff'd*, sub nom *National Permanent Federal Sav. & Loan Assn. v. Virginia Concrete Co., Inc.*, 562 F.2d 47 14th Cir. 1977).

- *Purgess v. Sharrock*, 33 F.3d 134, 139 (2d Cir. 1994) (state medical peer review privilege outweighed by need for discovery in antitrust action); and

- *Memorial Hospital v. Shadur*, 664 F.2d 1058, 1062 (7th Cir. 1981) (state medical peer review privilege outweighed by civil rights plaintiffs' need for discovery.)

Bredice v. Doctors Hospital, Inc., 50 F.R.D. 249 (D. D.C. 1970), *aff'd*, 479 F.2d 920 (D.C. Cir. 1973) was the first federal case to address the peer review privilege and remains the leading case. In *Bredice*, a plaintiff in a malpractice suit sought the production of defendant hospital's peer review materials that were created by committees of doctors acting pursuant to the requirements of the Joint Commission for the Accreditation of Hospitals. The *Bredice* court weighed the competing interests at stake and concluded that there was "an overwhelming public interest in having [physician peer review meetings] held on a confidential basis so that the flow of ideas and advice can continue unimpeded." *Id.* at 251. Accordingly, the district court held, and the Circuit Court for the District of Columbia affirmed, that the peer review privilege outweighed the litigant's right to discovery.

In *United States v. Harris Methodist Fort Worth*, 970 F.2d 94 (5th Cir. 1992), the United States sought a declaratory judgment that it was entitled to investigate physician staff privileges in a Title VI discrimination case. Citing Congressional recognition of the peer review privilege and *Bredice* with approval, the Fifth Circuit acknowledged the public policy in favor of the physician peer review privilege. (*United States v. Harris Methodist Fort*

Worth, supra 970 F.2d at 103.) Given that the *Harris* court had already determined that the proposed search was unreasonable, however, it decided not to define the scope of the privilege. At least one commentator has cited *Harris* for the proposition that "some courts have sought to . . . create a peer review privilege in circumstances outside academia, as in physician review panels."[15]

In *Memorial Hospital v. Shadur*, 664 F.2d 1058 (7th Cir. 1981), on the other hand, the Seventh Circuit considered a defendant hospital's petition to vacate a discovery order directing it to turn over peer review documents sought by plaintiff doctor in an antitrust case. The court ruled that plaintiff was entitled to those documents because his claim arose out of the disciplinary proceeding themselves. *Purgess v. Sharrock*, 33 F.3d 134, 139 (2d Cir. 1994) is in accord, but in *Syposs v. United States*, 179 F.R.D. 406 (W.D. N.Y. 1998), the district court ruled that the plaintiff patient's right to discovery in a medical malpractice case did not outweigh the defendant hospitals' interest in maintaining the confidentiality of peer review materials. There is thus widespread uncertainty as to whether, and under what circumstances, the peer review privilege will be given effect.

Confusion is also widespread as to the applicability of the self-critical analysis privilege in the medical peer review context. In *University of Pennsylvania v. Equal Employment Opportunity Commission*, 493 U.S. 182 (1990), the Court held that the self-critical analysis privilege did

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[15] James C. Francis IV, *Current Discovery Disputes*, C842 ALI-ABA 307, 316 (1993).

not extend to university peer review materials related to discrimination cases brought by the EEOC. No mention is made of the medical peer review privilege. Some courts have relied upon *University of Pennsylvania* to deny the medical peer review privilege, (*see, e.g., Syposs v. United States,* 179 F.R.D. 406, 411-412 (W.D. N.Y. 1998) while others have distinguished *University of Pennsylvania* in the medical peer review context (*see, e.g., United States v. Harris Methodist Fort Worth,* 970 F.2d 94, 103 (5th Cir. 1992) ("[u]nlike the privilege claim for faculty tenure decisions rejected in *University of Pennsylvania v. EEOC,* . . . the medical peer review process 'is a sine qua non of adequate hospital care.' " (citing *Bredice v. Doctors Hospital, Inc., supra* 50 F.R.D. at 250).[16] Courts attempting to address the federal self-critical analysis privilege have noted the inconsistences.[17] In light of these conflicting cases, certiorari should be granted so that the law applicable to the peer review privilege may be properly resolved by this Court.

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[16] *See also Weekoty v. United States,* 30 F. Supp. 2d 1343, 1345 (D.N.M. 1998) ("[b]ecause of this unique role in preserving the public health, medical morbidity and mortality reviews must be distinguished from other peer review cases").

[17] *See, e.g., Holland v. Muscatine General Hospital,* 971 F. Supp. 385, 390 (S.D. Iowa 1997) ("[t]he self-critical analysis privilege has had an ambiguous existence, neither uniformly adopted nor rejected"); *Morgan v. Union Pacific Railroad Co.,* 182 F.R.D. 261, 264 (N.D. Ill. 1998) ("[g]iven the vast array of inconsistent decisions on this issue, it would be understatement to say that it is unclear whether a federal self-critical analysis privilege exists").

II. CERTIORARI SHOULD BE GRANTED TO ADDRESS THE ISSUE OF WHETHER STATE OR FEDERAL PRIVILEGE LAW APPLIES IN FEDERAL CASES INVOLVING STATE AND FEDERAL CLAIMS. [*JAFFEE V. REDMOND*, 518 U.S. 1 (1996).]

This Petition offers the Court the opportunity to resolve an issue identified but expressly left undecided in *Jaffee v. Redmond*, 518 U.S. 1, 15 n.15 (1996):

> We note that there is disagreement concerning the proper rule in cases such as this in which both federal and state claims are asserted in federal court and relevant evidence would be privileged under state law but not under federal law . . . . Because the parties do not raise this question and our resolution of the case does not depend on it, we express no opinion on the matter.

This Court thus has left open the question of whether federal or state privilege law should be applied in mixed claim cases. Petitioner, of course, does not have mixed claims pending against him, just state claims. Under the plain language of Rule 501, he should be permitted to assert and enforce the privilege. If this Court so finds, then the proper disposition of this case would be to grant Dr. Schug's petition for certiorari and summarily reverse the decision below.[18]

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[18] As this Court reasoned in *Jaffee v. Redmond*, 518 U.S. 1, 15 n.15 (1996):

> [I]f petitioner had filed her complaint in an Illinois state court, respondents' claim of privilege would surely have been upheld, at least with respect to the state wrongful death action. An Illinois statute

Nonetheless, the Court has left unresolved the source of *any* privilege in supplemental jurisdiction cases. Every evidentiary privilege relied upon by litigants – be it peer review, the clergyman-penitent privilege or the scope of the work product rule – is compromised, because the holder cannot determine whether he is protected by the provisions of state law or federal common law. This uncertainty imposes significant transaction costs and may lead to unjust and inconsistent litigation results.

Unlike the petition in *Jaffee*, this Petition raises the issue directly: Dr. Schug is a defendant in federal court wholly as a result of the court's exercise of supplemental jurisdiction. He would unequivocally be able to assert the peer review privilege in state court. According to the federal courts below, however, he is barred from asserting that same privilege merely because he is in a federal forum. The Court can now determine whether this was the result contemplated by Congress when it wrote, "in civil actions and proceedings, with respect to an element of a claim or defense as to which State law supplies the rule of decision, the privilege of a witness, person, government, State, or political subdivision thereof shall be determined in accordance with State law." FED. R. EVID. 501.

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provides that conversations between a therapist and her patients are privileged from compelled disclosure in any civil or criminal proceeding. Ill. Comp. Stat., ch. 740, § 110/10 (1994) . . . *Indeed, if only a state-law claim had been asserted in federal court, the second sentence in Rule 501 would have extended the privilege to that proceeding.* (Emphasis added.)

In mixed claim cases either state law applies to the state-law causes of action[19] or federal law applies to the state-law causes of action. Common sense and the language of Federal Rule of Evidence 501 dictate the former. Otherwise, different privileges would apply in state and federal court, which would, in effect, nullify the privileges.[20]

While *Jaffee* did not decide the issue of what law applies, the opinion offers valuable guidance on how the issue should be decided. The Court identified at least three pivotal factors in determining whether federal common law should recognize the privilege:

- whether the privilege protects critically important interests;
- whether the states have endorsed the privilege; and
- whether the privilege was among those proposed during the revision of the Federal Rules of Evidence.

All three criteria are met in this case:

- the quality of health care is a critically important interest that is protected by the peer review privilege;

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[19] *Freeman v. Fairman*, 917 F.Supp. 586, 588 (N.D. Ill. 1996) ("In plain terms, state privilege laws apply to state claims.") *See also Motley v. Marathon Oil Co.*, 71 F.3d 1547, 1551 (10th Cir. 1995) (Motley "asserted both federal and state causes of action. As to the state causes of action, a federal court should look to state law in deciding privilege questions").

[20] *See Jaffee v. Redmond*, 518 U.S. 1, 13 (1996).

- the privilege has been universally adopted by all states; and

- it was the subject of one of the privileges proposed during the revision of the F.R.E.[21]

Federal Rule of Evidence 501 authorizes federal courts to define new privileges by interpreting "the principles of the common law . . . in the light of reason and experience." The Rule thus did not freeze the law governing privileges at a particular point in history, but rather directed courts "to continue the evolutionary development of testimonial privileges." *Trammel v. United States*, 445 U.S. 40, 47 (1980). Though federal law favors broad discovery, there are exceptions for the "public good transcending the normally predominant principle of utilizing

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[21] "The uniform judgment of the States is reinforced by the fact that a psychotherapist privilege was among the nine specific privileges recommended by the Advisory Committee in its proposed privilege rules." *Jaffee v. Redmond*, 518 U.S. at 13. With regard to the present case, the first of those nine specific privileges, Proposed Federal Rule of Evidence 502, created an evidentiary privilege for required reports: "A person, corporation, association, or other organization or entity, either public or private, making a return or report required by law to be made has a privilege to refuse to disclose and to prevent others from disclosing the return or report, if the law requiring it so provides." *Tharp v. Sivyer Steel Corp.*, 149 F.R.D. 177, 179 n.4 (S.D. Iowa 1993) (quoting PROPOSED FED. R. EVID. 502). State and federal law require peer review, so peer review proceedings would fall within this "required reports" exception. Though the proposed specific privileges were not adopted, the failure to adopt them should not be construed as a disapproval of their content. *Jaffee v. Redmond*, 518 U.S. at 15. Instead, the existence of a specific proposed privilege relating to the one asserted by Dr. Schug argues strongly for the Court's adoption of the peer review privilege under *Jaffee*. *Id.*

all rational means for ascertaining truth" or if the exception "promotes sufficiently important interests to outweigh the need for probative evidence." *Id.* at 50-51 (citation omitted). Without question, preserving the health and well-being of the public (as well as the legitimate policy prerogatives of the states) qualifies as such "public good."[22]

III. THERE IS AN INTERCIRCUIT SPLIT ON THE FUNDAMENTAL QUESTION OF WHEN A PARTY HAS THE RIGHT TO PURSUE A DIRECT APPEAL TO ASSERT A PRIVILEGE.

Dr. Schug's Petition presents the Court with an issue of extreme importance to litigants nationwide: When can a party who is without other recourse seek interlocutory appellate review from the federal courts to protect a privilege? A privilege, after all, is only as strong as the procedural means for asserting and protecting it.

The Court in *Perlman v. United States*, 247 U.S. 7 (1918) created an exception to the final judgment rule to answer this very question, but the circuits have since differed widely in defining the scope of the exception. In

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[22] Petitioner Schug endorses the related petition filed by Petitioners Redbud Community Hospital and Adventist Health, Inc., which raises the issue of the availability of peer review privileges in EMTALA cases. Dr. Schug, however, cannot be sued under EMTALA and so is named only in state claims. He has lost a valuable privilege simply because plaintiffs chose to file their complaint in the federal courthouse. That result is not rational. Thus, this case presents an excellent vehicle for resolving the issue of what privilege applies in federal supplemental jurisdiction cases.

Perlman, a grand jury issued a subpoena to obtain records from Perlman's bookkeeper. The Court recognized that under the final judgment rule Perlman was "powerless to avert the mischief of the order but must accept its incidence and seek a remedy at some other time and in some other way." The Court, however, was "unable to concur" with such an unjust result, so it created an exception that allowed the discovery's "target" to take a direct appeal from an order compelling someone else to disclose privileged or confidential information. *Id.* at 13.

The *Perlman* exception to the final judgment rule is widely recognized, but a clear conflict among the circuits has developed over its scope. Notably, the Ninth Circuit below refused to decide Dr. Schug's interlocutory appeal, construing its decision in *In re National Mortgage Equity Corp.*, 857 F.2d 1238 (9th Cir. 1988), so narrowly that it essentially eliminates the *Perlman* exception altogether.[23] The Fourth Circuit likewise limits *Perlman* to "disinterested" third parties, and thus would likely not permit Dr. Schug's appeal.[24]

By contrast, other circuits have read *Perlman* more expansively. For example, the District of Columbia Circuit interpreted the *Perlman* exception broadly, in a way that would surely encompass Dr. Schug: "The final-order doctrine, as a normal prerequisite to a federal appeal, is

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[23] The Ninth Circuit could have construed Dr. Schug's appeal as a permissive writ. *See Land v. Deeds*, 878 F.2d 318 (9th Cir. 1989). *See also* the Petition for Writ of Certiorari filed with the Court by co-parties Redbud Community Hospital and Adventist Health, Inc.

[24] *In re Pruett*, 133 F.3d 275, 281 n.10 (4th Cir. 1997).

not a barrier where it operates to leave the suitor 'powerless to avert the mischief of the order.' " *Nixon v. Sirica*, 487 F.2d 700, 707 n.21 (D.C. Cir. 1973) (quoting *Perlman*).[25] The Eighth Circuit also seems to read *Perlman* expansively,[26] interpreting *Perlman* as an extension of the Fourth Amendment's protection against unreasonable searches and seizures.[27] The Tenth Circuit has consistently applied *Perlman* and once crafted an even broader exception to the final judgment rule,[28] though that has since been abandoned.[29]

On the other hand, the Eleventh Circuit interprets *Perlman* as permitting "an order denying a motion to quash to be considered final as to the injured third party

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[25] *See also In re Grand Jury Investigation of Ocean Transp.*, 604 F.2d 672 (D.C. Cir. 1979).

[26] *See In re Faltico*, 561 F.2d 109, 110 n.2 (8th Cir. 1977) ("this court overruled the motion challenging jurisdiction, since the subpoena was directed to a third party . . . who could not be expected to expose himself to the penalty of contempt in order to obtain appellate review").

[27] *Schwimmer v. United States*, 232 F.2d 855, 860 (8th Cir. 1956) ("Refusal of the District Court to quash, as an unreasonable search and seizure, a subpoena duces tecum issued in a grand jury investigation is a final or appealable order").

[28] *Covey Oil Co. v. Continental Oil Co.*, 340 F.2d 993 (10th Cir.), *cert. den.*, 380 U.S. 964 (1965).

[29] *Boughton v. Cotter Corp.*, 10 F.3d 746, 749-750 (10th Cir. 1993); *see also Company X v. United States*, 857 F.2d 710 (10th Cir. 1988).

who is otherwise powerless to prevent the revelation."[30] In the Seventh Circuit, *Perlman* functions primarily as a bulwark to protect the assertion of the attorney-client privilege.[31] At the same time, the circuit views *Perlman* as an "exceptional situation."[32]

The Fifth Circuit observes that courts are reluctant to recognize exceptions to the final order rule,[33] but also interprets *Perlman* as "permitting appeal where denial of immediate review would render impossible any review of the party's claims" – a formulation that would encompass Dr. Schug's appeal.[34] The First Circuit follows a parallel path: "Perlman has been viewed restrictively, as an example of 'the limited class of cases where denial of

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[30] *In re Grand Jury Proceedings*, 832 F.2d 554, 558 (11th Cir. 1987) (discussing motions to quash grand jury subpoenae).

[31] *See In re Klein*, 776 F.2d 628, 630 (7th Cir. 1985) ("the holder of a privilege [is permitted] to intervene in order to assert the privilege and to appeal from the rejection of the assertion. . . . The rejection of the claim is the final decision with respect to the intervenor. . . . [B]ecause the person summoned before the grand jury may testify rather than go to jail to support someone else's privilege, the rejection of the claim is final as a practical matter too").

[32] *In re Special March 1974 Grand Jury Possible Violations of Title 18 and 26, United States Code*, 541 F.2d 166, 169 (7th Cir. 1976).

[33] "The Supreme Court has acknowledged only a limited number of exceptions to the general rule that pre-contempt disclosure orders are not appealable. . . . All of the recognized exceptions are extremely narrow, and the lower courts have been exceedingly chary of enlarging their scope." *Branch v. Phillips Petroleum Co.*, 638 F.2d 873, 877-878 (5th Cir. 1981).

[34] *Id.* at 878.

immediate review would render impossible any review whatsoever of an individual's claims.' "[35]

The Third Circuit recognizes that "contempt citations are not the exclusive means by which third parties may appeal from trial court discovery orders. . . . The noncustodian who asserts an interest in the documents is not subject to the contempt requirement. The conceptual basis for the dichotomy is found in the teachings of *Perlman v. United States.*"[36] The Second Circuit also focuses on the contempt issue, concluding that *Perlman* only applies when the appellant has no other means of challenging a discovery order by being held in contempt.[37]

Significantly, the Second Circuit notes that *Perlman*'s obscure language has complicated the interpretation and application of the rule: "It is hardly surprising that so Delphic a deliverance should give rise to differing interpretations."[38]

Given such widely divergent readings of *Perlman*, the rights of privilege holders are not equally protected in federal courts. For privileges to have meaning, procedures for asserting them must be clear. The Ninth Circuit's dismissal of Dr. Schug's direct appeal presents the

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[35] *Corporacion Insular de Seguros v. Garcia*, 876 F.2d 254, 258 (1st Cir. 1989) (quoting *United States v. Ryan*, 402 U.S. 530, 533 (1971)).

[36] *United States v. Cuthbertson*, 651 F.2d 189, 193 (3d Cir. 1981).

[37] *National Super Spuds, Inc. v. New York Mercantile Exchange*, 591 F.2d 174, 178 (2d Cir. 1979).

[38] *Id.*

appropriate vehicle for this Court to determine the scope of the *Perlman* exception to the final judgment rule. This case, therefore, gives rise to an opportunity for this Court to address an important procedural question that would only come to the Court in a privilege case like this one. Accordingly, the Court should grant certiorari on this question.

CONCLUSION

The quality of health care for all Americans rests in the hands of this Court. Hospitals and health care professionals are watching the outcome of this case closely. They know that a failure of the Court to grant certiorari and address the issues raised in this case will result in crippling uncertainty about the confidentiality of peer review in federal courts. Such uncertainty would stifle practitioners' voluntary participation in our country's primary mechanism for monitoring the quality of health care. Moreover, the petition raises important questions about the scope and applicability of *every* privilege and the standing of privilege holders to assert them.

In this case, therefore, the Court has the power to profoundly impact the country's public health, while addressing a sensitive federal/state balance regarding the

respect federal courts should give to state privileges. For these reasons, this case merits review by the Court.

Respectfully submitted,

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APPENDIX A

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

In Re: REDBUD COMMUNITY HOSPITAL DISTRICT	No. 98-70610
REDBUD COMMUNITY HOSPITAL, ADVENTIST HEALTH, INC., Petitioner, v. UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF CALIFORNIA Respondent, and DAVIS [sic] BURROWS, Successor-In-Interest to Cody Burrows, Deceased; DAVID BURROWS and RHODA THOMAS, Individually and as Heirs and Surviving Parents of Cody Burrows, Real Party in Interest.	D.C. No. CV-96-04345-SI
WOLFGANG SCHUG, M.D., Petitioner, v. UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF CALIFORNIA, Respondent, and	No. 98-70616 D.C. No. CV-96-04345-SI

DAVIS [sic] BURROWS, Successor-In-Interest to Cody Burrows, Deceased; DAVID BURROWS and RHODA THOMAS, Individually and as Heirs and Surviving Parents of Cody Burrows,

Real Party in Interest.

No. 98-16089

D.C. No. CV-96-04345-SI

DAVID BURROWS, Successor-In-Interest; CODY BURROWS, Deceased; RHODA THOMAS, Individually and as Heirs and Surviving Parents of Cody Burrows,

Plaintiffs-Appellees,

v.

REDBUD COMMUNITY HOSPITAL DISTRICT; M. FRED BREWER; ADVENTIST HEALTH INC.; JJ&R EMERGENCY MANAGEMENT GROUP INC.; EMERGENCY MEDICAL MANAGEMENT SERVICES, INC.,

Defendants,

and

WOLFGANG SCHUG, M.D.,

Defendant-Appellant.

ORDER

Before: HUG, Chief Judge, FLETCHER, and TROTT, Circuit Judges.

The panel as constituted above has voted to deny the petition for rehearing. Judges Hug and Trott have voted to reject the suggestion for rehearing en banc, and Judge Fletcher so recommends.

The full court has been advised of the suggestion for rehearing en banc and no judge of the court has requested a vote on it. Fed. R. App. P. 35(b).

The petition for rehearing is DENIED and the suggestion for rehearing en banc is REJECTED.

APPENDIX B

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

In Re: REDBUD COMMUNITY HOSPITAL DISTRICT	No. 98-70610
REDBUD COMMUNITY HOSPITAL, ADVENTIST HEALTH, INC., Petitioner, v. UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF CALIFORNIA Respondent, and DAVID BURROWS, Successor-In-Interest to Cody Burrows, Deceased; DAVID BURROWS and RHODA THOMAS, Individually and as Heirs and Surviving Parents of Cody Burrows, Real Party in Interest.	D.C. No. CV-96-04345-SI
WOLFGANG SCHUG, M.D., Petitioner, v. UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF CALIFORNIA, Respondent, and	No. 98-70616 D.C. No. CV-96-04345-SI

DAVID BURROWS, Successor-In-Interest to Cody Burrows, Deceased; DAVID BURROWS and RHODA THOMAS, Individually and as Heirs and Surviving Parents of Cody Burrows,

Real Party in Interest.

DAVID BURROWS, Successor-In-Interest; CODY BURROWS, Deceased; RHODA THOMAS, Individually and as Heirs and Surviving Parents of Cody Burrows,

Plaintiffs-Appellees,

v.

REDBUD COMMUNITY HOSPITAL DISTRICT; M. FRED BREWER; ADVENTIST HEALTH INC.; JJ&R EMERGENCY MANAGEMENT GROUP INC.; EMERGENCY MEDICAL MANAGEMENT SERVICES, INC.,

Defendants,

and

WOLFGANG SCHUG, M.D.,

Defendant-Appellant.

No. 98-16089

D.C. No. CV-96-04345-SI

ORDER*

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* This disposition is not appropriate for publication and may not be cited to or by the courts in this circuit except as provided by Ninth Circuit Rule 36-3.

Appeals from the United States District Court for the Northern District of California Susan Yvonne Illston, District Judge, Presiding
Argued and Submitted October 7, 1998
San Francisco, California

Before: HUG, Chief Judge, FLETCHER, and TROTT, Circuit Judges.

Dr. Schug's appeal is dismissed for lack of jurisdiction. *See In re National Mortgage Equity Corp. Mortgage Pool Certificates Litigation*, 857 F.2d 1238, 1240 (9th Cir. 1988). The consolidated petitions for writs of mandamus are denied. *See Bauman v. United States District Court*, 557 F.2d 650 (9th Cir. 1977).

APPENDIX C

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

DAVID BURROWS and RHODA THOMAS,

Plaintiffs,

v.

REDBUD COMMUNITY HOSPITAL DISTRICT; ADVENTIST HEALTH INC.; J.J. & R. EMERGENCY MANAGEMENT GROUP, INC.; WOLFGANG SCHUG, M.D.; M. FRED BREWER, M.D. and DOES I through XXX.

Defendants.

_____/

No. C 96-4345 SI

ORDER:

1. DENYING PLAINTIFFS' MOTION TO STRIKE EX PARTE COMMUNICATIONS;
2. DENYING PLAINTIFFS' MOTION FOR SANCTIONS;
3. DENYING IN PART AND GRANTING IN PART DEFENDANTS' MOTION FOR RECONSIDERATION; and
4. RESOLVING PENDING DISCOVERY DISPUTES

INTRODUCTION

Cody Burrows, an eleven-month old infant, died after being transferred from Redbud Community Hospital to

Santa Rosa Community Hospital. David Burrows and Rhoda Thomas, Cody's parents, filed this lawsuit in federal court alleging violations of the federal Emergency Medical Treatment and Active Labor Act ("EMTALA"), as well as pendent state law claims for medical malpractice, wrongful death, emotional distress, and spoliation of evidence.

Defendants have requested reconsideration of this Court's "Order Regarding Applicability of California Evidence Code § 1157" filed January 13, 1998, in which the Court held that the state peer review privilege did not apply in the instant case. At issue were plaintiffs' discovery requests for documents produced during hospital peer review sessions after Cody Burrows' death. In the January 13 order, the Court first concluded that under EMTALA, federal law supplies the rule of decision, and therefore according to Federal Rule of Evidence 501, federal privilege law applies. Federal law does not recognize a peer review privilege. However, in the interest of comity the Court contemplated whether the state privilege should apply. The Court, relying on *Pagano v. Oroville Hospital*, 145 F.R.D. 683 (E.D. Cal. 1993), found that comity did not warrant the application of state privilege law.

Mindful of the then-pending criminal proceedings against defendant Schug, the Court waited to issue its order until Judge Warren rendered a decision regarding the applicability of Evidence Code § 1157 in the criminal context. On January 2, 1998, Judge Warren issued a ruling holding that § 1157 was inapplicable in the criminal proceedings against defendant Schug. This Court, no longer constrained by the impact its ruling on this issue might have on Dr. Schug's state criminal case, issued its order

on January 13, 1998. Immediately after this Court issued its order, defendants notified the Court by letter that the California Court of Appeals had stayed Judge Warren's ruling as the result of a Petition for Writ of Mandate and/or Prohibition or Other Appropriate Relief. Defendants also requested that this Court reconsider its opinion. On January 20, 1998, this Court granted defendants' request for reconsideration and set a briefing schedule on the matter. In the meantime, the Writ to the California Court of Appeals was denied on January 29, 1998. The defendants then petitioned the California Supreme Court for a stay and review. That petition was denied on February 4, 1998.

In addition to defendants' motion for reconsideration, the Court has before it plaintiffs' motion to strike defendants' allegedly *ex parte* communications with the Court, as well as plaintiffs' corresponding motion for sanctions. Plaintiffs argue that defendants' letters notifying the Court of the stay on Judge Warren's ruling and requesting reconsideration of this Court's order constituted impermissible *ex parte* communications.

DISCUSSION

A. Plaintiffs' Motions to Strike *Ex Parte* Communications and for Sanctions

Plaintiffs argue that defendants engaged in improper *ex parte* communications with the Court in violation of Civil Local Rule 11-3(c). Plaintiffs object that they were not provided prior notice of defendants' communications to the Court as required by the Local Rules, and that therefore these letters should be stricken. Plaintiffs argue

that defendants' letters invoke the power of the Court and seek judicial relief, thereby affecting plaintiffs' substantive rights. In addition, plaintiffs specifically object to the letter sent by Robert Lynch, counsel for defendant Schug, on the ground that although the letter indicates that plaintiffs were copied, plaintiffs in fact never received a copy of the letter. Plaintiffs request sanctions against Mr. Lynch.

Defendants respond that they have not engaged in *ex parte* communications with the Court because plaintiffs were copied on all correspondence. Defendants state that they sent letters to the Court because they viewed the matter as a discovery dispute, and had been previously informed to notify the court of such disputes by letter brief. With regard to the letter sent by defendant Schug, Mr. Lynch states that the failure to copy plaintiffs was due to inadvertent clerical error, but that plaintiffs were not prejudiced since defendant Schug sought the same relief – reconsideration – as sought by the other defendants.

As the Court has already decided to reconsider its January 13, 1998 order. In the Court's view, these letters were not impermissible *ex parte* communications, as plaintiffs' counsel was copied on all letters save one. As to defendant Schug's letter to the Court which plaintiffs never received, the Court is persuaded that the error was inadvertent and that counsel for defendant Schug did not act in bad faith. Accordingly, the Court DENIES plaintiffs' motions to strike and for sanctions.

B. Defendants' Motion for Reconsideration

Defendants advance numerous arguments in favor of their motions for reconsideration. To the extent that defendants reargue the same points, the Court will not reconsider these arguments. However, the Court will reconsider the new arguments raised by the parties.

Defendants first argue that plaintiffs' request for the peer review records only applies to the state law claim of spoliation, and thus state privilege law should apply to this claim. However, defendants' arguments fail for two reasons. First, plaintiffs contend that the records are relevant because the defendants, and other unknown persons who may be members of the Peer Review Committee, conspired to alter, destroy and falsify Cody's medical records with regard to the care and treatment he received during his stay at Redbud. This contention is common to all causes of action, including the federal cause of action under EMTALA. As such, federal privilege law governs.

Second, assuming arguendo that the evidence was relevant only to the spoliation claim, Federal Rules of Evidence dictate that privileges asserted in federal question cases shall be governed by federal law. State privilege law applies to purely state law claims brought in federal court pursuant to diversity jurisdiction. However, state law claims that are pendent to federal question cases are governed by federal privilege law. *See Wm. T. Thompson, Co. v. General Nutrition Corp., Inc.*, 671 F.2d 100, 104 (3d Cir. 1982); *Pagano v. Oroville Hospital*, 145 F.R.D. 683 (E.D. Cal. 1993); *Perrignon v. Bergen Brunswig Corp.*, 77 F.R.D. 455, 458-459 (N.D. Cal. 1978). In the instant case the Court's jurisdiction is grounded on 28 U.S.C. § 1331

based on plaintiffs' EMTALA claims. Thus, federal privilege law applies.

Defendants next argue that even if federal privilege law applies, FRE 501 provides that in the absence of a controlling statute, courts look to common law principles to determine the applicability of evidentiary principles. *See Teasdale v. Marin General Hospital*, 138 F.R.D. 691, 694 (N.D. Cal. 1991). Federal courts in the Ninth Circuit have not yet adopted California's peer review privilege. Therefore, as provided by FRE 501, the question of whether § 1157 applies in federal court is "governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience" FRE 501. Reason and experience dictate that the Courts, in the interest of comity, look to state privilege law to ascertain the interests at stake.

Courts have held that there is no federal common law or statutory privilege protecting peer review medical records when the plaintiff's claim arises out of the disciplinary proceedings themselves. *See Pagano v. Oroville Hospital*, 145 F.R.D. 683, 691 (E.D. Cal. 1993) (holding that federal common law does not recognize medical peer review privilege in antitrust cases where the peer review itself is under attack). Courts have, however, recognized a peer review privilege in medical malpractice cases. *See Bredice v. Doctors Hospital*, 50 F.R.D. 249 (D. D.C. 1970), *aff'd* 479 F.2d 920 (D.C. Cir. 1973). Courts have drawn a distinction between medical malpractice and antitrust cases by reasoning that in medical malpractice cases the issue is whether the defendant was negligent in his care of the patient, not what transpired at a subsequent date during a peer review proceeding. *See Bredice*, 50 F.R.D.

249. In addition, disclosure of information contained in the peer review meetings would have little impact on a plaintiff's ability to prove his case. *See id.* On the other hand, in antitrust cases the claims arise out of the disciplinary proceedings themselves, and thus discovery is permitted since there would be no other source of the information. *See Memorial Hospital for McHenry County v. Shadur*, 664 F.2d 1058, 1062 (7th Cir. 1981).

Defendants argue that an EMTALA claim is essentially a medical malpractice claim, and thus the reasoning of the medical malpractice cases should apply. However, EMTALA claims are not grounded in tort concepts. *See Griffith v. Mt. Carmel Medical Center*, 842 F. Supp. 1359 (D. Kan. 1994). A plaintiff's claim in an EMTALA action does not rest on any proof that defendant was negligent, but rather is predicated on the hospital's violation of the EMTALA statute making the hospital strictly liable. Therefore, the Court is not persuaded that an EMTALA claim is analogous to a medical malpractice claim and thus does not apply the reasoning of those cases. In addition, the Court is persuaded that to the extent plaintiffs allege that Dr. Schug may have been instructed to create the addendum and burn his notes at the peer review meeting, plaintiffs' claim for spoliation of evidence and EMTALA depend on communications made during the peer review proceedings. Thus, this case is more like the antitrust cases than medical malpractice cases, since part of the claims arise out of the peer review meetings. Therefore, barring any overriding policy concerns, the state privilege does not apply in federal court.

Defendants argue that overriding policy concerns dictate that the state privilege should apply. First, they

argue that because state law requires medical practitioners to participate in the peer review sessions, it is unfair to then allow discovery of these meetings. Cal. Bus. & Prof. Code § 2282; Cal. Health & Saf. Code § 32128. Furthermore, defendants argue that § 1157 was instituted to encourage doctors to speak freely at such meetings in an effort to improve the quality to care. Therefore, defendants argue that the California legislature, in enacting § 1157, made a statutory promise to physicians that their self-critical commentary in peer review sessions would not be publicly disclosed. However, the action has been brought in federal court, and federal law, rather than state law, applies. Furthermore, recognizing a privilege under § 1157 would be inconsistent with the federal policy against privileges and in favor of broad disclosure.

Defendants also raise several constitutional issues. First, defendant Schug argues that emergency room doctors are more likely to be implicated in EMTALA actions than other doctors because EMTALA prevents the transfer of medically unstable patients, a situation more frequently encountered in the emergency room. Therefore, defendant Schug argues that disclosing peer review records creates a constitutionally-suspect distinction between emergency room physicians and other doctors in California. Defendant reasons that if peer records are discoverable in EMTALA actions, emergency room doctors cannot rely on confidentiality, whereas non-emergency room doctors can rely on this protection.

The Court is not persuaded by such reasoning. The status of being an emergency room doctor is not a protected characteristic warranting strict scrutiny analysis;

therefore, any classification resulting from this Court's order must meet the rational basis test. As long as there is some rational basis for the classification, the equal protection clause is not implicated. Here, the federal policies favoring disclosure and discovery in order to ascertain truth in the litigation context provide a rational basis for the classification, and therefore defendant's equal protection rights have not been violated.

Defendant Schug also argues that disclosure of the peer review records will deprive him of due process of the law. He contends that the right to pursue an occupation is a fundamental right, therefore, the government cannot impair his right to practice his profession without due process. *See Ender v. Schutzbank*, 68 Cal. 2d 162, 169 (1968). However, defendant Shug's [sic] reasoning is flawed because he is being accorded due process since he is receiving a full hearing in which he can present his defense. *See id.* at 172. Therefore, defendant fails to convince the Court that disclosure will violate his due process rights.

Finally, defendant Schug argues that disclosure will violate his right to privacy in the peer review records. California recognizes a constitutional right to privacy which is consistent with federal law and therefore can be considered in deciding whether or not to disclose the peer review records. *See Pagano*, 145 F.R.D. at 695. The Court considers the following factors in determining the scope of protection to be accorded in the privacy context:

> (1) [T]he probable encroachment of the individual's privacy right if the contested action is allowed to proceed, and the magnitude of the encroachment; (2) whether the encroachment of

> the privacy right would impact an area that has traditionally been off limits from most regulation; (3) whether the desired information is available from other sources with less encroachment of the privacy right; (4) the extent to which the exercise of the individual's privacy rights impinge on the rights of others; and (5) whether the interests of society at large encourage a need for the proposed encroachment.

Pagano, 145 F.R.D. at 698-99.

In *Pagano*, the Court reasoned that fourth and fifth factors, which both bear on the policies favoring discovery, outweighed the first two factors which bear on the degree of encroachment. This is because discovery and admissibility of relevant truthful information affect the individual rights of litigants as well as the public interest. As one court has noted, "litigation has the tendency to make public the sort of information that individuals would otherwise prefer to keep private. Public disclosure, in the end, is not only natural and generally unavoidable but also necessary and healthy to a process so dependent on truth and accuracy." *Cook v. Yellow Freight System, Inc.*, 132 F.R.D. 548, 551 (E.D. Cal. 1990) (as cited in *Pagano*, 145 F.R.D. at 699). In addition, the names of patients and physicians were kept confidential in order to minimize the degree of encroachment upon the privacy rights of individuals. Finally, because the information sought was not available from other sources, the third factor also weighed in favor of disclosure.

In applying the five factors above, the Court finds the reasoning in *Pagano* persuasive. Here, the only relevant information is that directly related to the care of Cody.

Furthermore, in Dr. Shug's [sic] criminal trial, the peer review records have already been discovered. Therefore, the balance of the five factors enumerated above, as well as the overall federal policy favoring broad disclosure, convince this Court that disclosure does not impermissibly violate Dr. Schug's right to privacy, especially since the information has already been revealed in the criminal context.

In conclusion, the Court finds that the hospital peer review records are discoverable, subject to a protective order. The parties are directed to submit a stipulated protective order providing for disclosure but ensuring the privacy of the physicians other than Dr. Shug [sic]. The Court, may at a later time and for good cause shown, entertain a motion for disclosing the identity of the physicians insofar as it is relevant to the plaintiffs' case. The information disclosed pursuant to this order shall be designated as "Confidential Material," and shall be used solely in connection with this litigation, or related appellate procedures, and not for any other purpose.

C. Pending discovery disputes

During a case management conference on February 23, 1998, counsel for plaintiffs informed the Court that he believed there were numerous unresolved discovery disputes pending before the Court. Plaintiffs have since submitted a letter identifying these pending disputes, which plaintiffs contend are still pending from plaintiffs' Motion to Compel submitted October 22, 1997. It is this Court's understanding, as well as defendants', that this

Court's November 3, 1997 order resolved all the discovery disputes as raised in plaintiffs' motion, except those dependent upon the Court's ruling on the applicability of § 1157. In the interest of clarity, the Court will reiterate what is already contained in the November 3, 1997 order: (1) defendants Redbud and Adventist have not waived their privileges because a privilege log had been produced; (2) plaintiffs are limited to 25 interrogatories per defendant; (3) defendant Adventist is ordered to produce documents #2, 6, 8, and 9; (4) defendant Redbud is ordered to produce documents # 14 and 17. Furthermore, because the Court is now ruling that § 1157 is not applicable in federal court, to the extent that defendants objected to any discovery disputes on the basis of the applicability of § 1157, they are now ordered to respond.

Defendant Adventist correctly notes that if the Court rules that § 1157 is not applicable, Adventist will be required to answer plaintiffs' First Set of Interrogatories to defendant Adventist Health. However, Adventist is only required to answer numbers 1, 2a, 2b, 2c, 3e, 3f, 3g, 3h, 3i, 3j, 4, 5a, 5b, 5c, 5d, 5e, because this comports with the 25 interrogatory limit imposed in the Court's November 3, 1997 Order. In addition, Adventist concedes that it will have to produce Mr. Schultz for further deposition if § 1157 is not applicable. However, because Mr. Schultz has been previously deposed, this deposition should be limited to subject matter thought to be protected by § 1157 which is no longer protected.

Defendant Schug requests further opportunity to brief the issues regarding his deposition, interrogatories and document production because he contends that previous briefing focused primarily on his fifth amendment

rights. The Court declines to grant this request because the parties have been given ample time to raise all objections. As such, any discovery which was withheld on the basis of § 1157 is now ordered to be produced, including interrogatories, depositions, and documents.

With respect to the deposition of Ms. DeLashmutt, the Court construes plaintiffs' request as a motion to complete her deposition. The Court has read the portions of the deposition submitted by plaintiffs and will allow plaintiffs to complete the deposition because it agrees that defendants' counsel impermissibly coached Ms. DeLashmutt. All parties should be advised that objections should not be used to attempt to coach a witness. *See Hall v. Clifton Precision*, 150 F.R.D. 525, 531 (E.D. Pa. 1993). All objections to form of the question should be succinct and clearly state the objection. Further objections based on privilege should merely state the privilege asserted.

CONCLUSION

For the foregoing reasons, plaintiffs' motion to strike *ex parte* communications and for sanctions is DENIED and defendants' motion for reconsideration is DENIED in that § 1157 does not apply in federal court, but is GRANTED with respect to a protective order of materials discovered.

IT IS SO ORDERED.

Dated: May 5, 1998

/s/ Susan Illston
SUSAN ILLSTON
United States District Judge

APPENDIX D

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

DAVID BURROWS, et al., Plaintiffs, v. REDBUD COMMUNITY HOSPITAL DISTRICT, et al., Defendants. _____/	No. C 96-4345 SI **ORDER REGARDING APPLICABILITY OF CALIFORNIA EVIDENCE CODE § 1157**

In their objections to a number of plaintiffs' discovery requests, defendants Redbud and Adventist raised claims of privilege under California Evidence Code § 1157, which substantially limits discovery into the proceedings and records of hospital medical staffs concerned with evaluation and improvement of the quality of care in a hospital. During an earlier discovery conference, plaintiffs sought to compel responses to the challenged discovery requests, contending that the limitations imposed on California courts by § 1157 do not apply in federal court.

Plaintiffs then-pending discovery disputes were partially resolved by this Court's order filed November 3, 1997. However, at that time Superior Court Judge Warren had under submission the question of whether Evidence Code § 1157 applied in the state criminal case pending against Dr. Schug: prosecutors were seeking, and defendant Schug was resisting, production of such records. In

the interest of protecting Dr. Schug's right to a fair criminal trial, this Court refrained from ruling on the applicability of § 1157 in the federal context until the state court had issued its ruling on the matter.

On January 2, 1998, Judge Warren issued a ruling, holding § 1157 was inapplicable in the criminal context presented there, thereby allowing prosecutors to subpoena hospital records claimed to be privileged under § 1157. *In re Search Warrant No. 13489*, San Francisco Superior Court, 1/2/98. Given Judge Warren's ruling, this Court is no longer constrained by the impact its ruling on this issue might have on Dr. Schug's state criminal case.

For the following reasons, the Court concludes that § 1157 is not applicable in this action.

DISCUSSION

Section 1157 provides that proceedings and records of hospital medical staffs concerned with evaluation and improvement of the quality of care in the hospital shall not be subject to discovery. California Evidence Code § 1157 (West 1997). The section further states that no person who attends a meeting of these committees shall be required to testify as to what transpired at that meeting. *Id.*

The existence of privilege in cases in federal court is governed by Rule 501 of the Federal Rules of Evidence, which provides:

> [T]he privilege of a witness, person, government, State, or political subdivision thereof shall

> be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience. However, in civil actions and proceedings, with respect to a claim or defense as to which State law supplies the rule of decision, the privilege of a witness, person, government, State, or political subdivision thereof, shall be determined in accordance with State law.

Defendants assert that § 1157 applies in this action because of the Emergency Medical Treatment and Active Labor Act of 1986 ("EMTALA"), 42 U.S.C. § 1395dd, incorporates state damages law to the extent that plaintiffs are allowed to "obtain those damages available for personal injury under the law of the state in which the hospital is located." 42 U.S.C. § 1395dd(d)(2)(A). Defendants argue that state law therefore provides the rule of decision, and thus state privilege law governs. Plaintiffs counter that § 1157 is inapplicable in a federal question case such as the instant action, and that when federal and state claims are joined in the same action, claims of privilege are determined under federal law. *See William T. Thompson Co. v. General Nutrition Corp.*, 671 F.2d 100, 104 (3d Cir. 1982).

This issue appears to be one of first impression. Plaintiffs are correct that ordinarily federal privilege law applies in federal question cases. However, EMTALA is unlike many federal laws in that it incorporates state law, thus requiring a different analysis of the issue than that put forth by plaintiffs.

Other courts have faced a question similar to that presented here when applying state privileges to federal

actions under the Federal Tort Claims Act. The Federal Torts Claim Act [sic] requires federal courts to look to the law of the state where the act or omission occurred in order to determine government liability. 28 U.S.C. § 1346(b). Thus, the Federal Tort Claims Act, like EMTALA, incorporates state tort law to some extent. In *Menses v. United States Postal Services*, 942 F. Supp. 1320 (D. Nev. 1996), the court held that the incorporation of state law did not mean that "state law supplies the rule of decision" for purposes of FRE 501. *Accord Young v. United States*, 149 F.R.D. 199 (S.D. Cal. 1993). In reviewing the legislative history of FRE 501, the *Menses* court stated, "Congress recognized that when federal courts merely adopt state law as federal law, there is no need to apply state law in matters such as the admissibility of evidence and claims of privilege, and that federal privilege law controls. It is only where state law is operative of its own force that state law supplies the rule of decision, and, under Rule 501, state privilege law governs." *Id.* at 1322. A state law is self-operative if state law provides the source of the right sued upon. In these cases, "no federal interest justifies overriding a state substantive law such as evidentiary privileges, and to do so would promote forum shopping and lead to an inequitable administration of the laws between state and federal courts." *Id.* In contrast, if the right sued upon has a federal source, then state law is incorporated or adopted as federal law, and federal interests in applying federal evidence rules and privileges outweigh any countervailing state interests.

The Court concludes that FRE 501 does not require the application of § 1157 to the instant action. In an EMTALA action, state substantive law is not operative of

its own force. Rather, EMTALA establishes federal requirements for medical screening, stabilizing treatment, and restriction of transfers until the patient is stabilized. 42 U.S.C. § 1395dd(a)-(c). The statute creates a private right of action under *federal law* against offending hospitals, and incorporates state law only in the determination of damages.

Although federal courts are not required to apply state privileges law to federal question cases, federal courts may do so in the interest of comity. "[A]s a matter of comity, federal courts should attempt to ascertain what interests inspire relevant state doctrine and should take into account the views of state authorities about the importance of those interests." *Kelly v. City of San Jose*, 114 F.R.D. 653, 656 (N.D. Cal. 1987). In determining whether to apply a state privilege, a federal court should first analyze whether application of the state law would be inconsistent with federal law. *See Pagano v. Oroville Hospital*, 145 F.R.D. 683, 688 (N.D. Cal. 1993). If the state law is not inconsistent, the federal court should attempt to apply the state privilege in harmony with federal privileges law.

In *Pagano v. Oroville Hospital*, the court declined to apply § 1157 to a federal antitrust action, finding there is no clearly recognized federal peer review privilege and that § 1157 is too absolute in its application and effect, and therefore too inconsistent with federal law, to be applicable. *Id.* at 690. The court reasoned that disclosure in that case was necessary because the evidence sought was relevant to the plaintiff's allegations that the hospital had conspired to eliminate the plaintiff as a competitor in providing medical services.

The Court finds the *Pagano* court's reasoning instructive, and declines to apply § 1157 to the instant case. Section 1157 acts as an absolute shield against discovery, and this Court agrees with the *Pagano* court that such absolute protection against discovery is inconsistent with the flexibility of federal privilege law. Plaintiffs have alleged that defendants conspired to falsify Cody Burrows' medical records, and that the evidence they are seeking – to which defendants have raised claims of privilege under § 1157 – is relevant to their spoliation of evidence claim. As a general matter, the Court finds that such evidence may be relevant to this claim, and holds that § 1157 is inapplicable in this action. Defendants may, of course, raise other claims of privilege to these documents if applicable.

IT IS SO ORDERED.

Dated: January 9, 1998

/s/ Susan Illston
SUSAN ILLSTON
United States District Judge

APPENDIX E

California Evidence Code § 1157
(California's Peer Review Privilege)

§ 1157. Proceedings and records of organized committees having responsibility of evaluation and improvement of quality of care; exceptions

(a) Neither the proceedings nor the records of organized committees of medical, medical-dental, podiatric, registered dietitian, psychological, or veterinary staffs in hospitals, or of a peer review body, as defined in Section 805 of the Business and Professions Code, having the responsibility of evaluation and improvement of the quality of care rendered in the hospital, or for that peer review body, or medical or dental review or dental hygienist review or chiropractic review or podiatric review or registered dietitian review or veterinary review or acupuncturist review committees of local medical, dental, dental hygienist, podiatric, dietetic, veterinary, acupuncture, or chiropractic societies, or psychological review committees of state or local psychological associations or societies having the responsibility of evaluation and improvement of the quality of care, shall be subject to discovery.

(b) Except as hereinafter provided, no person in attendance at a meeting of any of those committees shall be required to testify as to what transpired at that meeting.

(c) The prohibition relating to discovery or testimony does not apply to the statements made by any person in attendance at a meeting of any of those committees who is a party to an action or proceeding the subject

matter of which was reviewed at that meeting, or to any person requesting hospital staff privileges, or in any action against an insurance carrier alleging bad faith by the carrier in refusing to accept a settlement offer within the policy limits.

(d) The prohibitions in this section do not apply to medical, dental, dental hygienist, podiatric, dietetic, psychological, veterinary, acupuncture, or chiropractic society committees that exceed 10 percent of the membership of the society, nor to any of those committees if any person serves upon the committee when his or her own conduct or practice is being reviewed.

(e) The amendments made to this section by Chapter 1081 of the Statutes of 1983, or at the 1985 portion of the 1985-86 Regular Session of the Legislature, or at the 1990 portion of the 1989-90 Regular Session of the Legislature, do not exclude the discovery or use of relevant evidence in a criminal action.

APPENDIX F

PEER REVIEW PRIVILEGE STATUTES OF THE 50 STATES

ALA. CODE § 22-21-8 (1997)

ALASKA STAT. §§ 18.23.030, 18.23.070 (Michie 1997)

ARIZ. REV. STAT. § 36-445.01 (1997)

ARK. CODE ANN. §§ 20-9-304, 20-9-503 (Michie 1997)

CAL. EVID. CODE § 1157 (Deering 1997)

COLO. REV. STAT. § 13-21-110 (1997)

CONN. GEN. STAT. § 19a-17b (1997)

DEL. CODE ANN. tit. 24, § 1768 (1997)

D.C. CODE ANN. § 32-505 (1997)

FLA. STAT. ch.766.101 (1997)

GA. CODE ANN. §§ 31-7-133, -140, -143 (1997)

HAW. REV. STAT. § 624-25.5 (1997)

IDAHO CODE §§ 39-1392, 39-1392a-f (1997)

225 ILL. COMP. STAT. ANN 60/5, 735 ILL. COMP. STAT. ANN. 5/8-2101 (West 1997)

IND. CODE ANN. §§ 34-30-15-1 to -3, -8, -9 (Michie 1998)

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LA. REV. STAT. ANN. § 13: 3715.3 (West 1998)

ME. REV. STAT. ANN. tit. 32, § 3296 (West 1997)

MD. CODE ANN., HEALTH OCC. §§ 14-501, 14-503 (1997)

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MICH. STAT. ANN. § 14.15 (21515) (Law. Co-op. 1997)

MINN. STAT. § 145.64 (1997)

MISS. CODE ANN. § 41-63-9 (1997)

MO. REV. STAT. § 537.035 (1997)

MONT. CODE ANN. §§ 7137-2-201, 50-16-201 to 205 (1997)

NEB. REV. STAT. ANN. §§ 71-2046 to -2048 (Michie 1997)

NEV. REV. STAT. ANN. § 49.265 (Michie 1997)

N.H. REV. STAT. ANN §§ 151:13-a, 329:29 (1997)

N.J. STAT. ANN. § 2A:84A-22.8 (West 1997)

N.M. STAT. ANN § 41-9-5 (Michie 1997)

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N.C. GEN. STAT. § 131E-95 (1997)

N.D. CENT. CODE §§ 23-34-01 to -03 (1997)

OHIO REV. CODE ANN. §§ 2305.251, 2305.252 (Anderson 1998)

OKLA. STAT. tit. 63, § 101709 (1997)

OR. REV. STAT. § 41.675 (1997)

PA. STAT. ANN. tit. 63, §§ 425.2, 425.4 (West 1997)

R.I. GEN. LAWS § 5-37.3-7 (1997)

S.C. CODE ANN. §§ 40-71-10, -20 (Law. Co-op. 1997)

S.D. CODIFIED LAWS § 36-4-26.1 (Michie 1998)

TENN. CODE ANN. § 63-6-219 (1997)

TEX. REV. CIV. STAT. ANN. art. 4495b (West 1998)

UTAH CODE ANN. §§ 26-25-1, -3 (1997)

VT. STAT. ANN. tit. 26 §§ 1441, 1443 (1997)

VA. CODE ANN. § 8.01-581.17 (Michie 1997)

WASH. REV. CODE ANN. § 4.24.250 (West 1997)

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WIS. STAT. § 146.38 (1997)

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MOTION FILED
MAY 5 1999

No. 98-1526

In The Supreme Court of the United States

WOLFGANG SCHUG, M.D.,
Petitioner,

vs.

DAVID BURROWS, successor-in-interest to Cody Burrows, deceased; DAVID BURROWS and RHODA THOMAS individually and as heirs and surviving parents of Cody Burrows
Respondents.

On Petition For Writ of Certiorari To The United States Court of Appeals For The Ninth Circuit

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF *AMICUS CURIAE* FOR THE PHYSICIAN INSURERS ASSOCIATION OF AMERICA SUPPORTING PETITIONER

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MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF *AMICUS CURIAE*

The Physician Insurers Association of America hereby respectfully moves for leave to file the attached brief *amicus curiae* in the above-referenced case. The consent of the attorney for Petitioner has been obtained. However, the consent of the attorney for the Respondents was requested but refused. Accordingly, the Physician Insurers Association of America hereby moves for leave to file the attached brief *amicus curiae*.

The Physician Insurers Association of America represents doctor and dentist owned or operated professional liability insurers insuring approximately sixty percent of America's private practice physicians as well as dentists, hospitals and other health care providers. Accordingly, the Physician Insurers Association of America has a strong interest in the resolution of the current uncertainty that exists in the lower courts regarding the applicability of the state medical peer review privilege when physicians, hospitals or other health care providers are drawn into a federal forum when pendent state claims against them are permissively joined with a federal question.

Participating as *amicus curiae*, the Physician Insurers Association of America hopes to aid the Court in its consideration of the petition for a writ of certiorari by providing insight into the centrality of the medical peer review process to health care quality assurance, and the consequent need to ensure the integrity of the medical peer review privilege.

Respectfully Submitted,

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Respondents.

BRIEF FOR THE PHYSICIAN INSURERS ASSOCIATION OF AMERICA AS AMICUS CURIAE SUPPORTING PETITIONER

INTEREST OF AMICUS CURIAE [1]

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[1] Pursuant to Rule 37.6 of the Rules of this Court, counsel hereby certifies that the brief submitted on behalf of amicus curiae Physician Insurers Association of America was not authored in whole or in part by counsel for a party, and no person or entity other than the Physician Insurers Association of America and its members has made a monetary contribution to the preparation of this brief.

The Physician Insurers Association of America ("PIAA")is a non-profit trade association comprised of more than 60 professional liability insurance companies owned and/or operated by doctors and dentists. The membership of the PIAA includes forty-seven physician and dentist owned and/or operated companies in the United States, four reinsurance companies, and nine international members in Australia, France, Great Britain, and the Netherlands. Collectively, these companies insure approximately sixty percent of America's private practice physicians as well as dentists, hospitals and other health care providers. The focus of the PIAA's activities is on issues and developments that are likely to impact member companies, the availability and affordability of professional liability insurance, and the ability of the policyholders of the member companies to deliver quality health care. In this role, PIAA has sponsored numerous research, educational, legislative and regulatory initiatives aimed at improving the quality of and access to health care while reducing costs.

Because the medical peer review system is the single most important risk management mechanism for ensuring a continued high quality of medical care, PIAA is extremely concerned that any uncertainty regarding the availability of the state medical peer review privileges regardless of forum could have a severe chilling effect on peer review, and consequent adverse effects for health care quality and cost of care. The PIAA would urge the Court to grant Petitioner's Petition for Writ of Certiorari to resolve the important question of the applicability of state medical peer review privileges in federal question cases with pendent state law claims.

SUMMARY OF ARGUMENT

Over the last several decades, the health care delivery system in the United States has undergone a dramatic transformation with the rise of managed care and the transformation of hospitals and medical groups into much more sophisticated entities. Methods of promoting quality assurance and protecting patient safety reflect this transformation as well. Whereas the individual physician was once the only guarantor of the quality of care provided, now the individual physician is complemented by a second tier of quality assurance in the form of the medical peer review committee that exists in hospitals, medical groups, health maintenance organizations ("HMO's"), medical societies and other physician organizations.[2] Medical peer review has become the central quality assurance mechanism for monitoring the competence of physicians and ensuring that patients receive the highest quality of medical care. Medical peer review has been recognized as essential to health care quality by accrediting bodies, state medical licensing boards, state legislatures and the United States Congress. Medical peer review provides a superior mechanism to reliance on the medical malpractice system or overwhelmed and often underfunded state medical licensing boards.

In order to foster vigorous peer review, these proceedings must remain privileged and practitioners must be able to rely on the privilege being applied with certainty. Practitioners and policymakers alike have concluded that the peer review

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[2]*See* Note, *Restructuring Hospital-Physician Relations: Patient Care Quality Depends on the Health of Hospital Peer Review*, 51 U. PITT. L. REV. 1025, 1025-31 (1990) (describing evolution of hospital quality assurance).

privilege is essential to the effective functioning of the medical peer review process. Indeed, all fifty states and the District of Columbia provide some level of protection from disclosure or discovery of peer review records. The policies served by the medical peer review privilege will be undermined if practitioners cannot be certain that the peer review privilege will not be vitiated purely because they are fortuitously drawn into a federal forum when pendent state claims lodged against them as co-defendants are permissively joined with a federal question. Continued uncertainty in this area merits review by this Court.

ARGUMENT

1. Medical Peer Review is the Prevailing Method of Quality Assurance in the U.S. Health Care System

A. Medical Peer Review: How Does It Work?

Today medical peer review represents the most pervasive form of quality control at all levels of the U.S. health care system. Medical peer review is utilized by hospitals, HMO's, preferred provider organizations ("PPO's"), medical groups, medical societies and other health care entities to ensure quality care.

The medical peer review process performs numerous functions within the context of quality assurance. First, medical peer review serves a "gatekeeper" function in assessing the qualifications and competence of physicians through the credentialing process. The credentialing process typically employs peer review to review educational

qualifications, clinical competence, professional conduct, physical and mental health of practitioners seeking to be licensed or seeking to join hospital medical staffs, medical groups, HMO's, managed care panels, medical associations or societies, and a host of other professional organizations for physicians. In hospitals, the medical peer review system allows for ongoing monitoring to ensure that a physician maintains the necessary skills and professional competence for the clinical privileges he/she possesses and plays an important role in the biennial physician reappointment process.

Second, medical peer review provides an ongoing quality assurance mechanism to identify problems with the quality of care received in particular cases. Cases identified through quality assurance safeguards are typically reviewed by departmental or specially constituted peer review committees to assess the quality of care provided and direct necessary remedial actions or monitoring. Finally, medical peer review serves as an important educational tool. The purpose of the medical peer review committee process is to provide a forum for frank and open discussion among colleagues for the purpose of educating all involved. Often peer review will involve difficult cases or unexpected medical outcomes. Providing a forum for candid assessments of these cases allows practitioners to learn from one another so that the best quality patient care can be provided in such situations. Thus, the medical peer review system serves as a vital educational tool for physicians as well as being a credentialing and disciplinary device. While it may not be possible to produce a system that will allow for error-free quality of care, medical peer review presents the best mechanism for addressing quality of care issues as they arise.

B. Medical Peer Review Has Been Recognized as Essential to Health Care Quality By Congress, and is Required for Accreditation, Participation in Federal Programs and by Many States

While congressional recognition of the importance of peer review to ensuring quality care can be traced as far back as the establishment of Professional Standards Review Organizations ("PSRO's") in 1972 to review the quality of care being received by inpatients participating in the Medicare program, the central role of medical peer review has been firmly established most recently by congressional enactment of the Health Care Quality Improvement Act ("HCQIA"), 42 U.S.C. §§ 11101-52. In enacting this legislation, Congress expressly found as follows:

> (1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any state.
>
> ...
>
> (3) This nationwide problem can be remedied through effective professional peer review.
>
> ...

(5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

Id. at § 11101. Congress attached sufficient importance to the peer review process as a means to ensure health care quality that it saw fit to make express findings regarding the essential function of peer review and to provide immunity from civil actions based on peer review when conducted within certain parameters.[3] *See Id.* at 11111-12.

In addition to congressional recognition, medical peer review is so essential to quality care as to merit its inclusion in the standards that must be met for the accreditation of health care organizations. The accreditation of most health care organizations providing health care in the United States, including hospitals, health care networks, PPO's and managed care organizations ("MCO's"), is performed by nongovernmental entities that have adopted standards for accreditation that are widely recognized throughout the health

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[3]Although some may contend that the fact that Congress did not enact a federal peer review privilege at the time that it enacted other peer review protections under HCQIA suggests congressional intent to deny such a privilege, a review of the legislative history, *see* H.R. REP. NO. 99-903 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6384, reveals that Congress did not consider—much less consider and reject—such a privilege as required to infer legislative intent to deny the privilege in a federal forum. *See, e.g., Century Southwest Cable Television, Inc. v. CIIF Associates*, 33 F.3d 1068, 1071 (9th Cir. 1994) (citing *Russello v. United States*, 464 U.S. 16, 23-24 (1983)) (stating that congressional intent to reject provision can be presumed where Congress includes, but subsequently deletes provision from legislation).

care industry.[4] The Joint Commission on the Accreditation of Health Care Organizations ("JCAHO") is the primary organization involved in the accreditation of hospitals, and also provides accreditation for health care networks and PPO's. JCAHO's accreditation standards have recognized the vital importance of peer review to ensuring the quality of medical care, and consequently require that hospitals and other health care entities maintain peer review systems in order to receive accreditation. *See* JOINT COMMITTEE ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS, ACCREDITATION MANUAL FOR HOSPITALS MS 1 (1996). The National Committee for Quality Assurance ("NCQA"), the primary accrediting entity for managed care organizations ("MCO's"), similarly requires that accredited entities have in place mechanisms to monitor, evaluate and improve the quality of care received by the MCO's enrollees. *See* NAT'L COMM. FOR QUALITY ASSURANCE, 1998 STANDARDS FOR CERTIFICATION OF PHYSICIAN ORGANIZATIONS.

In addition to being required to secure accreditation, the implementation of an effective medical peer review system is a condition of participation in the federal Medicare program. *See* 42 C.F.R. § 482.22 (1999). Moreover, it has been the considered judgment of numerous state legislatures that medical peer review should be required by statute for entities operating within the state in order to ensure adequate care. *See, e.g.*, GA. CODE. ANN. § 31-7-15 (1998).

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[4]Indicative of the standard setting nature of these entities is the fact that JCAHO accreditation allows participation in the federal Medicare program without additional certification, *see* 42 U.S.C. § 1395bb, and numerous states similarly recognize JCAHO accreditation for licensure purposes.

D. Medical Peer Review is the Best Available Mechanism for Ensuring Health Care Quality

While the medical malpractice system and state medical licensing boards provide two other methods of addressing quality assurance in the practice of medicine, there are substantial shortcomings with each of these approaches, particularly with respect to the ability to provide ongoing monitoring of the quality of care.

According to research conducted by the American Medical Association, 8% of all physicians had at least one professional liability claim lodged against them in 1995 with higher-than-average claim rates for particular specialties and in certain regions of the country. *See* AMERICAN MEDICAL ASSOCIATION, SOCIOECONOMIC CHARACTERISTICS OF MEDICAL PRACTICE 1997 at 40-41. Yet the medical malpractice system has been shown to be a flawed and costly mechanism for addressing quality of care issues or compensating injured patients.

With respect to the medical malpractice system as a control on the quality of care, commentators have noted that the current liability system is ill-suited to that goal and may in fact impose additional costs on the health care system due to the practice of "defensive medicine." *See* Daniel P. Kessler and Mark B. McClellan, *The Effect of Malpractice Pressure on Physicians' Perceptions of Medical Care*, 60 LAW & CONTEMP. PROBS. 81, 81 (1997); PHYSICIAN PAYMENT REVIEW COMMISSION, 1995 ANNUAL REPORT TO CONGRESS at 318-19 (describing costs associated with current medical liability system). In addition, reliance on the medical malpractice system carries additional societal costs in the

form of higher costs to hospitals and other health care entities associated not only with increased insurance premiums, but also with additional costs related to claims management and settlement. *See* UNITED STATES GENERAL ACCOUNTING OFFICE, MEDICAL LIABILITY: IMPACT ON HOSPITAL AND PHYSICIAN COSTS EXTENDS BEYOND INSURANCE (1995). These costs are ultimately passed on to consumers and taxpayers in the form of higher health insurance premiums. Therefore, the medical malpractice system alone is unlikely to provide an effective mechanism for assuring quality care by physicians.

Nor has the medical malpractice system been shown to provide an effective system of compensating patients harmed by negligent medical care. The medical malpractice system's inefficiencies result in average delays of four to five years in disposing of medical malpractice claims. *See* Kessler & McClellan, *supra*, at 81. In addition, research shows that the medical malpractice claimant typically receives only half of the amount of indemnity and expenses incurred to compensate the injured party. PHYSICIAN INSURERS ASSOCIATION OF AMERICA, MEDICAL MALPRACTICE CLAIM EXPENSES: ANNUAL INCREASES OUTPACING INDEMNITY GROWTH (1997) at 6.

While state medical licensing boards serve an important function, they too suffer from limitations in their ability to provide the type of oversight and monitoring provided by the medical peer review system. A report prepared by the Department of Health and Human Services' Office of the Inspector General noted that "[q]uality-of-care cases are among the most difficult types of cases for state medical boards to address." *See* U.S. DEPT. OF HEALTH AND HUMAN SERVICES, OFFICE OF THE INSPECTOR GENERAL, STATE

MEDICAL BOARDS AND QUALITY-OF-CARE CASES: PROMISING APPROACHES at i (1993). Moreover, the report noted that state medical boards are often limited in their ability to pursue such cases by limited funding and resources. *Id.* at iv. Therefore, while state medical licensing boards serve an important function, they are hampered in their ability to fulfill the role of active and effective peer review. In fact, many state medical licensing boards depend on reports generated from medical peer review settings to serve as an initial screening and investigatory tool. *See, e.g.*, CAL. BUS. & PROF. CODE § 805 (West 1998). If peer review were weakened due to uncertainty surrounding the application of the peer review privilege, state medical licensing boards would also be adversely affected.

2. Medical Peer Review Privilege is Essential to the Effective Functioning of the Peer Review Process

While the oft-quoted passage from *Bredice v. Doctors Hospital, Inc.*, 50 F.R.D. 249, 250 (D.D.C. 1970), is perhaps the most frequently cited rationale for the medical peer review privilege, more telling perhaps is the following description offered by a practicing physician:

> The tort system makes adversaries out of patient and physician, and pushes each to offer a heavily slanted version of events...
>
> ...
>
> There is one place, however, where doctors can talk candidly about their mistakes, if not with patients, then at least with one another. It is called the Morbidity and Mortality Conference—or, more simply, M. & M.—and

> it takes place, usually once a week, at every teaching hospital in the country. This institution survives because laws protecting its proceedings from legal discovery have stayed on the books in most states, despite frequent legal challenges. Surgeons, in particular, take the M. & M. seriously. Here they can gather behind closed doors to review the mistakes, complications, and deaths that occurred on their watch, determine responsibility, and figure out what to do differently next time.

Atul Gawande, *Annals of Medicine: When Doctors Make Mistakes*, THE NEW YORKER, February 1, 1999, at 40, 48. While some commentators have suggested that the medical peer review privilege is not necessary to secure the participation of physicians in the peer review process,[5] the succinct statement above captures the impact of the privilege on physicians' perceptions of peer review which will be the determining factor in whether effective peer review takes place. Moreover, the peer review privilege allows physicians to openly and candidly assess medical quality issues to prevent future patient injuries.

The necessity of providing a privilege to safeguard the effective functioning of the medical peer review process is the result of the considered judgment of fifty state legislatures and

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[5]*See* B. Abbott Goldberg, *The Peer Review Privilege: A Law in Search of a Valid Policy*, 10 AM. J.L. & MED. 151, 154-55 (1984) (suggesting that the absence of the privilege would not end effective peer review); *see also,* Susan O. Scheutzow, *State Medical Peer Review: High Cost But No Benefit--Is It Time for a Change?*, 25 AM. J.L. & MED. 7 (1999) (suggesting that privilege will not necessarily remove reluctance to participate due to other disincentives not addressed by the privilege).

the District of Columbia (*see* Pet. App. F (collecting statutes)), all of which provide some type of protection against disclosure or discovery of peer review records. As this Court noted in *Jaffee v. Redmond*, 518 U.S. 1, 20 (1996) (citing *Trammel v. United States*, 445 U.S. 40, 48-50 (1980), and *United States v. Gillock*, 445 U.S. 360, 368, n. 8 (1980)), "[w]e have previously observed that the policy decisions of the States bear on the question whether federal courts should recognize a new privilege or amend an existing one." This Court further explained with respect to the patient-psychotherapist privilege that:

> any State's promise of confidentiality would have little value if the patient were aware that the privilege would not be honored in federal court. Denial of the federal privilege therefore would frustrate the purposes of the state legislation that was enacted to foster these confidential communications.

Jaffee at 20 (footnote omitted).

Among the questions presented for review by Petitioner is the question of whether a codefendant against whom only state claims are asserted and who has been permissively joined in a federal question case will nonetheless lose the protection of the state medical peer review privilege. Due to the nature of this issue, the applicability of the state medical peer review privilege in federal question cases has not received extensive treatment in the Circuit Courts. However, as Petitioner adequately sets forth in his petition for writ of certiorari, there is significant disarray in the district courts on this issue that merits further review by this Court. Both to provide needed certainty to physicians and in order to avoid

frustrating the purposes of state legislation, this Court should grant the petition for a writ of certiorari to resolve this question.

CONCLUSION

The petition for writ of certiorari should be granted because of the significant national importance of the question presented for review.

Respectfully submitted,

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Nos. 98-1513 and 98-1526

In The

Supreme Court of the United States

REDBUD COMMUNITY HOSPITAL,
ADVENTIST HEALTH, INC.,

vs. *Petitioners,*

UNITED STATES DISTRICT COURT, NORTHERN DISTRICT OF CALIFORNIA, DAVID BURROWS, RHODA THOMAS,

Respondents,

and

WOLFGANG SCHUG, M.D.,

vs. *Petitioner,*

DAVID BURROWS, successor-in-interest to Cody Burrows, deceased; DAVID BURROWS and RHODA THOMAS individually and as heirs and surviving parents of Cody Burrows,

Respondents.

On Petitions For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

RESPONDENTS' CONSOLIDATED BRIEF IN OPPOSITION TO BOTH PETITIONS FOR WRITS OF CERTIORARI

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COUNTER-STATEMENT OF QUESTIONS PRESENTED

The district court issued an interlocutory discovery order for production of hospital records, names of witnesses, and other evidence that petitioners wish to conceal. The court effectively denied petitioner Schug's request to certify the order for immediate appeal pursuant to 28 U.S.C. Sec. 1292. The order as to documents was directed not to Schug, but only to the hospital petitioners, because only they had custody of the supposedly privileged materials.

Petitioner Schug nevertheless filed a purported appeal as of right, ignoring the general rule against uncertified interlocutory appeals in civil cases. The appeal was, therefore, summarily dismissed based on controlling Ninth Circuit authority, which is consistent with Supreme Court and other circuits' authority, that parties to a civil case may not have automatic interlocutory appeals of discovery orders, unlike third-party witnesses served with grand jury subpoenas.

Both Schug's and the Hospitals' separate petitions for writs of mandamus also were summarily denied by the 9th Circuit, based on authority in that Circuit, which again is consistent with authority of the U.S. Supreme Court, that mandamus will not lie unless the district court abused its discretion by issuing a clearly erroneous ruling. Accordingly, the Ninth Circuit's rulings on both the appeal and the mandamus petitions were contained in a single one-page, unpublished order.

Based on this history, the *actual* questions presented, which would have to be decided favorably to petitioners

COUNTER-STATEMENT OF QUESTIONS PRESENTED – Continued

before this Court could consider the questions of substantive "privilege" law they present, are:

(1) Should the Court of Appeals for the Ninth Circuit have issued a writ of mandamus to overturn an interlocutory district court civil discovery order on the ground of a purported state (not federal) law medical peer review "privilege," where no showing was made that the order was clearly erroneous and hence an abuse of discretion, in light of the admissions in the briefs below and in both petitions here that applicability of this state "privilege" under federal law has been rejected by numerous federal courts and thus is at best a debatable proposition?

(2) Does a party in civil litigation who claims he would be irreparably harmed by release of documents held by another party in the case have the right to automatic interlocutory appeal, after being denied discretionary leave to appeal, to challenge the discovery order on the ground that the materials are "privileged"?

Respondents submit that the answers to both questions are well settled in the negative and are unworthy of review by this Court. First, petitioners do not come even close to meeting the high standard for the extraordinary remedy of mandamus. Second, the purported interlocutory appeal is conclusively barred by longstanding statute, case law, and judicial policy.

Respondents submit that the petitions should be summarily denied on that basis and that the tendentious questions posed by petitioners cannot and need not be

COUNTER-STATEMENT OF QUESTIONS PRESENTED – Continued

reached given the procedural posture of this interlocutory proceeding.

Moreover, the questions in both petitions as to whether the purported privilege should apply to respondents' state law claims for medical malpractice as well as to their federal claims for EMTALA violations are red herrings. The district court's order pertains solely to discovery of the records from the hospital and does not reach the admissibility of the records in the trial of the state or federal law claims; thus it is not accurately described as a ruling on "privilege" at all. As only release is at issue, it would make absolutely no difference at this stage whether this case contained only the federal EMTALA claim or, as it does, both state law and federal claims. In either event, the only two possible outcomes are that the records are either released to respondents or they remain concealed.

PARTIES TO THE PROCEEDINGS

The two petitions accurately list the parties to the proceedings.

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I.

COUNTER-STATEMENT OF THE CASE

The petitions should be denied because, very simply, this is the wrong case for the United States Supreme Court to consider what might otherwise be interesting questions of privilege law (or, more accurately, of civil discovery law). There are three decisive reasons for this.

(1) Petitioners fail to appreciate, or at least to point out for this Court, that the interlocutory nature of the challenged discovery order is fatal to their campaign for appellate review. It is no accident that the Ninth Circuit, after full briefing and oral argument, issued an *unpublished* order summarily denying both the Hospitals' and Dr. Schug's petitions for mandamus and summarily dismissing Dr. Schug's separate appeal. There is no reason to believe the Ninth Circuit failed to understand from the lengthy briefs (two rounds per side) and oral argument that the issues presented were of *potentially* significant legal interest. But that Court, like this Court, is not inclined to ignore equally important legal doctrines that bar the type of piecemeal, interlocutory delay of civil case discovery orders that these petitioners have so far created.

Thus, the Ninth Circuit summarily disposed of this matter because the separate appeal was barred under clear authority against the very type of interlocutory derailment of ongoing civil litigation Dr. Schug improperly perpetrated by filing it, and has exacerbated by bringing to this Court. And the mandamus petitions were flawed because petitioners' presentation to the Ninth Circuit, like the one they make here, proved that the district

court could not have abused its discretion — needed to justify reversal by that extraordinary writ — because the existence of the purported privilege under federal law was, at best, debatable.

(2) This also is the wrong case *on the facts* for the seminal review of federal privilege (or discovery) law that petitioners want this Court to undertake. They present the case as though it involved nothing more than a discovery attempt by respondents, approved by the district court, to strike at California's protection for doctors to express their candid opinions of medical services rendered by other doctors, or even for an accused doctor to be candid about his own work. But that is *not* the thrust of respondents' discovery effort and that was *not* the fact situation as it appeared to the district court.

Rather, the district court did *not* rule that respondents are entitled to the so-called peer review documents, witness names, and other information because it thought plaintiffs in *every* case ought to be allowed to see what other doctors thought of a defendant doctor's work. Rather, the court based its decision on evidence that the peer review process had been corrupted by misconduct separate from the underlying EMTALA violations or medical malpractice Dr. Schug committed. The hospital petitioners, though not petitioner Schug, note this in passing (at p. 6 of Hospitals' petition), but breezily dismiss it.

But these facts, as the district court itself said, were crucial to its decision because the apparent corruption within the peer review process itself brings this case closer to numerous federal cases, including antitrust and

employment discrimination complaints, as well as California state cases involving alleged criminal violations, where the state privilege has been overridden due to similar process corruption facts. Such cases, like this one, are quite unlike petitioners' model of doctors being forced to reveal what they said about other doctors. That is, respondents are not seeking opinions, but rather facts, documents and the identity of witnesses that would prove the process was corrupted.

Respondents contend that principal defendant Schug, perhaps aided and abetted by others at the Hospital, violated the California Penal Code by fraudulently creating a false medical record to cover up gross misconduct. Schug indeed admitted under oath the bizarre act of burning his original notes in a bonfire at his home. Such violation of law would not entitle the hospital to the privilege even under California state law, contrary to petitioners' false assertion that it is "undisputed" the state privilege would bar the discovery if there were no federal claims in this case. And even if there were no criminal violation, proof of such independent spoliation of evidence would also arguably eliminate the state privilege, even if state law instead of federal law were to apply.

The district court thus wrote: "[T]o the extent plaintiffs allege that Dr. Schug may have been instructed to create the [false] addendum and burn his notes at the peer review meeting, plaintiff's claims for spoliation of evidence *and EMTALA* depend on communications made during the peer review proceedings. Thus, this case is more like the antitrust cases than medical malpractice cases, since part of the claims arise out of peer review meetings." Hospital Pet. App. 16 (emphasis added).

Although the Hospital petitioners do quote this passage in their brief, they give it a misleading spin by immediately adding that the district court "did not state why it would not delay discovery until plaintiffs explained in greater detail how the Hospital's peer review process was involved in the claims plaintiffs were asserting, nor did it say why it would not conduct an *in camera* review of the documents." Hospital Pet. 6.

But respondents provided the district court as much explanation as they could — without actually seeing the withheld evidence — of how the Hospital's peer review process apparently was corrupted. Whether the district court needed to make an *in camera* review of the concealed evidence is within that court's zone of discretion and surely cannot be an appropriate matter for review by the United States Supreme Court. The discovery record in this case already includes at least 25 depositions, four volumes of grand jury testimony in criminal proceedings against Dr. Schug, and hundreds of documents that contain thousands of pages. All this material was available to the district court prior to its determination that respondents had presented a sufficiently plausible allegation of direct corruption of the peer review process to justify discovery of relevant records, and some of it was reviewed by that court.

It borders on the absurd for petitioners to invite the United States Supreme Court to intervene, on an *interlocutory* basis in this civil proceeding, to upset the district court's determination of whether and to what extent this evidence supports the discovery sought by respondents under the well-recognized exception, even when a state privilege is otherwise applicable, for situations where the

peer review process is, itself, corrupt or otherwise implicated in the predicate facts of the case.

(3) Both petitions present a purported legal question that was not the primary basis for the district court's decision. That question, therefore, is not properly before this Court. That is, even if this Court were to accept it for review and decide it favorably to petitioners, the district court's ruling would still have to stand based on that court's primary — and independent — ground for decision.

Petitioners argue that this case presents a proper vehicle for decision of a question purportedly left open by this Court in *Jaffee v. Redmond*, 518 U.S. 1 (1996), which they describe as being whether "state law claims that are pendent to federal question cases are governed by federal privilege law." Hospital Pet. 11 (quoting Hosp. Pet. App. 14). The district court did opine that respondents' state law claims against Dr. Schug and the Hospital would be "governed" by federal privilege law.

But that opinion was presented by the district court merely as an *alternative* ground for its ruling "assuming arguendo that the [peer review] evidence was relevant only to the [state law] spoliation claim." (Hospital Pet. App. 14.) Both petitioners overlook, however, that the court had just given its *primary* ground for decision that rendered the alternative ground mere surplusage:

> "Defendants first argue that plaintiff's request for the peer review records only applies to the state law claim of spoliation, and thus state privilege law should apply to this claim. However, defendants' arguments fail for two reasons. First, plaintiffs contend that that the

> records are relevant because the defendants, and other unknown persons who may be members of the Peer Review committee, conspired to alter, destroy, and falsify Cody [Burrows'] medical records with regard to the care and treatment he received during his stay at Redbud [Hospital]. *This contention is common to all causes of action, including the federal cause of action under EMTALA. As such federal privilege law governs."* (Hospital Pet. App. 14, emphasis added.)

That ruling alone is sufficient to justify the district court's order granting respondents discovery of the alleged peer review information. Nothing the court went on to gratuitously add "arguendo" about purported applicability of the privilege to the state law claims can add or subtract anything from the adequate basis for that ruling. Even if there were no state law claims in this case at all, the district court's discovery order would stand on its own purely federal law foundation based on that court's study of the facts of this case which is inappropriate for interlocutory review by the Supreme Court.

Moreover, the district court's "arguendo" separate ground refers to the information's potential relevance to state law spoliation claims, but not to the separate state law claims for medical malpractice. But as Petitioner Schug mentions in passing in a footnote not linked to discussion of the purported *Jaffee v. Redmond* issue, the state law spoliation claim no longer exists. On May 11, 1998, just six days after the district court's opinion just quoted, the California Supreme Court abolished that as a valid state law cause of action. *Cedars-Sinai Medical Center v. Superior Court (Bowyer)*, 18 Cal.4th 1, 954 P.2d 511, 74 Cal.Rptr.2d 248 (1998), cited in Schug Pet. 3 n.2.

In essence, therefore, petitioners are seeking a merely advisory opinion by this Court pertaining to an issue that was not even necessary to the district court's decision in the first place and which, in any event, was effectively mooted by the California Supreme Court just a few days afterwards.

We emphasize that both petitioners' presentations of this case as one concerning "privilege" is misleading. While California Evidence Code Sec. 1157 could be viewed as establishing a form of privilege by implication, the statute in terms refers only to *discovery* of documents. It does not determine whether documents, once discovered, would be admissible as evidence at trial. See *Alexander v. Superior Court*, 5 Cal.4th 1218, 1223 n.4, 23 Cal.Rptr.2d 397, 859 P.2d 96 (1993) ("Evidence Code Sec. 1157 creates only a privilege against discovery from medical staff committees; it does not create a bar against introduction of evidence.") The district court has made no ruling on whether any peer review information, once released to respondents, would be admitted.

Thus, while the state law claims of malpractice do remain in this case, the potential *Jaffee v. Redmond* issue of whether federal "privilege" law would govern their admissibility as to those state claims is not yet ripe for decision. That is because, of course, the district court has not yet had occasion to rule on that question.

This is yet another reason why petitioners' persistence in interlocutory delay of this civil case is so obviously improper. If and when purportedly privileged documents are admitted into evidence in support of respondents' state malpractice claims, and an adverse

judgment is rendered against one or both petitioners, their *Jaffee v. Redmond* questions might at least arguably (without conceding the point) be worthy of certiorari review by this Court.

II.

LEGAL ARGUMENTS FOR DENYING THE WRITS

A. Neither Petition Even Attempts to Argue That Any Novel Issue of Mandamus Law Is Presented By The Ninth Circuit's Unpublished Summary Denial of Writs of Mandamus Against An Interlocutory Discovery Order. The Petitions, In Fact, Demonstrate Effectively, and Thus Concede, That There Is Sufficient Conflicting Authority That The District Court's Discovery Order Cannot Possibly Meet the Abuse of Discretion/Clearly Erroneous Standard for Mandamus Relief.

Petitioners would have this Court leap over the procedural posture of this case and conduct a plenary examination of federal medical "privilege" (discovery) law as though the Ninth Circuit had already done that in a published opinion in a case properly before it on appeal from a final judgment. This, of course, is not the case.

The reason the Ninth Circuit summarily declined petitioners' invitation is the same reason this Court should do so: The district court's opinion is light-years short of the clearly erroneous/abuse of discretion that is necessary for the extraordinary remedy of mandamus to reverse an interlocutory discovery order. Indeed, this Court's strictures against mandamus in such situations

appear to be materially stronger even than those uniformly applied followed by the courts of appeal.

Petitioners cannot escape the decisive threshold issue of mandamus law merely by alleging, as they do, that this Court has jurisdiction of their petitions under the general certiorari statute, 28 U.S.C. Sec. 1254(1), rather than under the separate statute, 28 U.S.C. Sec. 1651, that gives this Court power to issue "all writs necessary or appropriate." Although petitioners are not asking the Supreme Court directly to issue writs of mandamus to the district court, their request for reversal of the Ninth Circuit's summary action is that this Court order the Ninth Circuit to issue those writs of mandamus. That, obviously, is tantamount to the Supreme Court's directly issuing the writs.

It is well settled that this Court will not issue (or order the issuance of) writs of mandamus against interlocutory district court orders absent truly extraordinary circumstances. Orders that are not appealable by reason of their interlocutory nature may not ordinarily be reviewed by mandamus, even though the hardship of a prolonged trial "is imposed on parties who are compelled to await the correction of an alleged error at an interlocutory stage by an appeal from a final judgment." *United States Alkali Association v. United States*, 325 U.S. 196, 202 (1945); *Roche v. Evaporated Milk Association*, 319 U.S. 21, 25-32 (1943); *Bankers Life Co. v. Holland*, 346 U.S. 379, 382-83 (1953); *Will v. United States*, 389 U.S. 90, 96-98 (1961); *Parr v. United States*, 351 U.S. 513, 520 (1956). Mandamus writs "are drastic and extraordinary remedies [to be] reserved for really extraordinary causes." *Ex parte Fahey*, 332 U.S. 258, 259 (1947); *Will, supra*, 389 U.S. at

106-07. "The power to issue [the writs] is discretionary and it is sparingly exercised." *Parr, supra*, 351 U.S. at 520.

This Court has repeatedly emphasized that mandamus, which can have "the unfortunate consequence of making the [district court] judge a litigant" — as is the case here at least with the Hospitals' petition — should be restricted to extraordinary situations in order to implement the long-standing congressional policy against piecemeal appellate litigation, "particularly in an era of excessively crowded lower court dockets." *Kerr v. United States District Court*, 426 U.S. 394, 402-03 (1976) (unanimously upholding Ninth Circuit's summary denial of petition for writ of mandamus on alleged ground, as here, that district court's discovery order violated purported privilege). To that end, the party seeking the writ must show that his right to it is "clear and indisputable." *Id.*

The Supreme Court has long refused to issue, or order lower courts to issue, writs of mandamus to control or reverse the discretionary acts of district courts. *Ex parte Bradley*, 7 Wall. 364 (1863); *Ex parte Parker*, 120 U.S. 737 (1887). Because the district court was exercising power within its zone of discretion, the Supreme Court more recently went out of its way to *reverse* the issuance of writs of mandamus by courts of appeal in *Will v. Calvert Fire Insurance Co.*, 437 U.S. 659 (1978), and *Allied Chemical Corp. v. Daiflon, Inc.*, 437 U.S. 659 (1978). These cases underscore the important policy against using mandamus and other extraordinary writs as a means to obtain appellate review of non-appealable interlocutory orders.

The Ninth Circuit followed its own case law, which is to similar effect as the foregoing Supreme Court cases, when it summarily refused to overturn the district court's interlocutory discovery by writ of mandamus. It was clear enough even under the Circuit's law that petitioners did not even come close to making a case for the extraordinary relief they sought.

The U.S. Supreme Court's even stronger statements of reluctance to use or order use of the writ adds a further barrier that petitioners cannot possibly overcome. For these petitions to be worthy of Supreme Court consideration, they would have to make a plausible case not merely that the district court was clearly erroneous and abused its discretion in ordering discovery, but that the Ninth Circuit was, itself, clearly erroneous and abused its discretion by not using mandamus to reverse the district court.

Petitioners have not made such showing — on either level of inquiry. Their presentation here and below of the apparent division of authority concerning the legal issue they want this Court to leap to decide constitutes a conclusive admission that their petitions do not present even an arguable case for mandamus to be ordered by this Court after full review.

The Ninth Circuit's order summarily denying mandamus cited, without comment, *Bauman v. United States District Court*, 557 F.2d 650, 654 (9th Cir. 1977), which holds, *inter alia*, that mandamus will not lie unless the district court's decision (a) was "clearly erroneous as a matter of law"; *and* (b) involved an important issue of first impression. Petitioners admit that they cannot satisfy

the first prong of this test, and they come close to admitting that they cannot satisfy the second prong.

Thus petitioners admit there is ample authority, albeit they disagree with it, supporting the district court's refusal to apply the California "privilege" (discovery prohibition) in federal question cases such as this one. This presumptively means the district court's decision cannot have been clearly erroneous as a matter of law. *See* cases discussed in Hospital Pet. 17-18; 20-23 (privilege "has had an ambiguous existence, neither uniformly adopted nor rejected" — at p. 21)) and Schug Pet. 13-16 ("the circuit courts have not treated the medical peer review privilege uniformly" — at p. 13).

Petitioners' presentations of pro and con cases in these sections of their brief are not as even-handed as they appear because the actual weight of federal on the medical peer review privilege tilts substantially further against it than petitioners' skewed case selection suggests. Nevertheless, petitioners have presented enough federal authority contra the privilege to foreclose the argument that the district court's order was clearly erroneous or an abuse of discretion.

Of course, the only reason petitioners were even-handed to any extent was their understandable desire to convince this Court that there is a sufficiently material difference of opinion in the lower courts to warrant Supreme Court review under the "conflict" criterion for certiorari. But, again, they have tried to leap a vast canyon in two successive jumps. The primary issue presented by *this* case, as opposed to the theoretical case

petitioners would like to generate for the Court's consideration, is whether the district court abused its discretion and whether the Ninth Circuit further abused its own discretion in not ruling, by mandamus, that the district court abused its discretion.

Petitioners are apparently correct that none of the published privilege cases to date (the instant district court opinion is unpublished just like the Ninth Circuit's order) has arisen under the particular federal law — EMTALA — at issue here. But that does not indicate that any truly novel issue of first impression is presented that would justify the extraordinary remedy of mandamus. In light of the breadth of federal question cases in which the purported peer review privilege has been discussed — and mostly denied application — no particular novelty or new analysis is required merely because EMTALA is the federal law involved here. Indeed, the claimed privilege under EMTALA is on all fours with a similar privilege claim under another federal statute, the Health Care Quality Improvement Act of 1986, which has been definitively rejected by at least six federal courts (indicated by parenthetical references to HCQIA in case list below).

Under Ninth Circuit authority, the absence of clear legal error was, alone, fatal to their request for mandamus. *Calderon v. United States District Court*, 98 F.3d 1102, 1105 (9th Cir. 1996); *Survival Systems of Whittaker Corp. v. United States District*, 825 F.2d 1416, 1418 n.1 (9th Cir. 1987) (the novelty or first impression test is irrelevant where no showing that court below was clearly erroneous). As Ninth Circuit Judge Dorothy Nelson points out in the leading Ninth Circuit practice guide: "[E]ven in

privilege cases, the court usually will intercede by mandamus only where petitioner can demonstrate clear error. *See Heathman v. United States District Court*, 503 F.2d 1032, 1035 (9th Cir. 1974) (petition denied where no clear error); *In re Grand Jury Subpoena Issued to Bailin*, 51 F.3d 203, 206 (9th Cir. 1995) . . . " Nelson, Goelz & Watts, *Ninth Circuit Civil Appellate Practice*, Sec. 13:168, p. 13-22.

That the district court's refusal, in this EMTALA case, to accord petitioners the benefit of California's peer review privilege is contrary to no published precedent by itself indicates, under Ninth Circuit authority, that the court's action cannot have been clearly erroneous. *See Wilson v. United States District Court*, 103 F.3d 828, 830 (9th Cir. 1996). Particularly when there is no contrary Ninth Circuit authority, and the ruling is consistent with decisions in other circuits, as the district court's was, the clear error standard cannot be met. *King v. United States District Court*, 16 F.3d 992, 993 (9th Cir. 1994).

While petitioners' effective admissions that the district court's order was neither an abuse of discretion nor clearly erroneous should be sufficient to foreclose mandamus and thus require denial of certiorari, we emphasize that petitioners' briefs present a misleading impression that the weight of legal authority pro and contra their position is more or less the same. In fact, federal privilege law is overwhelmingly hostile in general to new privileges not recognized as part of the common law in the original draft of the Federal Rules of Evidence and, specifically, to the purported peer review privilege.

In *University of Pennsylvania v. Equal Employment Opportunity Commission*, 493 U.S. 182, 110 S.Ct. 577 (1990),

a *unanimous* Supreme Court refused to recognize a state law peer review privilege with regard to university faculty evaluations. The Court strongly reiterated the long-standing rule that privileges are disfavored in federal practice, and that any privilege must be strictly construed, because "testimonial exclusionary rules and privileges contravene the fundamental principle that 'the public . . . has a right to every man's evidence.' " 493 U.S. at 189.

The Court considered all the arguments that petitioners here present, *i.e.*, that their interest in protecting the confidentiality of sensitive peer review materials outweighs plaintiffs' need for the evidence, that the evidence sought can be obtained through other means, that doctors (professors there) have relied on the privilege, and that it is unlikely they would honestly evaluate their colleagues in its absence. *Id.* at 192-93. The Court acknowledged that these concerns have some merit, but bluntly decided that the federal interest in remedying discrimination, and revealing evidence related to that purpose, is more important. *Id.*

Similarly, Congress' concern, under EMTALA, to curtail abuse of patients at hospital emergency rooms also is presumptively more important. Indeed, this Court was concerned that acceptance of the peer review privilege for faculty evaluations "would also lead to a wave of similar privilege claims by other employers who play significant roles in furthering speech and learning in society," *id.* at 585 — a group that obviously includes hospitals and doctors.

That Supreme Court decision both reflects, and further encourages, the overwhelming tide of federal court hostility to recognition both of the medical peer review privilege specifically and, generally, of new privileges that were unknown to prior federal common law but which were sought to be imported from state law or even from general legal scholarship. This true picture of the landscape of the case law refutes petitioners' hyperbolic rhetoric that the district court's unpublished order here has caused some *sui generis* breach in the sanctity of a universally-recognized (all 50 states, as both put it) peer review privilege that doctors have, supposedly, long comfortably counted upon to exist and be enforced.

A partial list of federal cases refusing to apply the medical peer review privilege to bar discovery follows. (Cases, referred to above, that refuse to recognize the peer review privilege under the Health Care Quality Improvements of Act of 1996, a federal statute on all fours with EMTALA, are noted in parentheticals as "HCQUIA.") *Wei v. Bodner*, 127 F.R.D. 91 (D.N.J. 1989), (HCQUIA case); *Robertston v. Neuromedical Center*, 169 F.R.D. 80 (M.D. La. 1996) (HCQUIA); *Pagano v. Oroville Hospital*, 145 F.R.D. 683 (E.D. Cal. 1993) (HCQUIA); *LeMasters v. Christ Hospital*, 791 F.Supp. 188, 191 (S.D. Ohio 1986) (HCQUIA); *Manthe v. Vanbolden*, 133 F.R.D. 497 (N.D. Tex. 1991) (HCQUIA); *Teasdale v. Marin General Hospital*, 138 F.R.D. 691, 694 (N.D. Cal. 1991) (HCQUIA); *Robinson v. Magovern*, 83 F.R.D. 79 (W.D. Pa. 1979); *Ott v. St. Luke Hospital*, 522 F.Supp. 706 (E.D. Ky. 1981); *Todd v. South Jersey Hospital System*, 152 F.R.D. 676, 683 (D.N.J. 1993); *Memorial Hospital for McHenry County v. Shadur*, 664 F.2d 1058, 1062-63 (7th Cir. 1981); *United States v. Illinois*,

148 F.R.D. 587, 588-89 (N.D. Ill. 1993); *Smith v. Alice Peck Day Memorial Hospital*, 148 F.R.D. 51, 56 (D.N.H. 1993); *Jiricko v. Coffeyville Memorial Hospital Medical Center*, 700 F.Supp. 1559, 1564 (D. Kan. 1988); *Doe v. St. Joseph's Hospital*, 133 F.R.D. 677, 680 (N.D. Ind. 1987); *Quinn v. Kent General Hospital*, 617 F.Supp. 1226, 1245 (D. De. 1985); *Schafer v. Parkview Memorial Hospital*, 593 F.Supp. 61, 65 (N.D. Ind. 1984); *Dorsten v. Lapeer County General Hospital*, 88 F.R.D. 583, 586 (E.D. Mich. 1980).[1]

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[1] A similar tide of federal authority has rejected federal application of state privileges in cases other than medical peer review. A by no means exhaustive list includes: *United States v. Wilson*, 960 F.2d 48, 50 (7th Cir. 1992) (refusing to apply state unemployment claims privilege); *In re Grand Jury Proceedings*, 5 F.3d 397, 402-03 (9th Cir. 1993) (no to state privilege for votes on academic promotions); *In re International Horizons, Inc.*, 689 F.2d 996, 1004-05 (11th Cir. 1982) (no to state accountant-client privilege); *FTC v. TRW*, 628 F.2d 207, 210 (D.C. Cir. 1980) (no to self evaluation privilege against federal agency subpoena); *Memorial Hospital for McHenry County v. Shadur*, 664 F.2d 1058, 1061 (7th Cir. 1981) (no to state medical peer review privilege; *Hancock v. Dodson*, 958 F.2d 1367, 1373 (6th Cir. 1992) (no to state doctor/patient privilege); *United States v. One Parcel of Property Located at 31-33 York Street*, 930 F.2d 139 (2d Cir. 1991) (no to state privilege re erased arrest records); *Sexton v. Poole Truck Lines, Inc.*, 888 F.Supp. 127 (M.D. Ala. 1994) (no to state privilege re sealed driving records); *Equal Employment Opportunity Commission v. Illinois Dep't of Employment Security*, 995 F.2d 106, 109 (7th Cir. 1993) (no to state privilege re unemployment hearings); *Linde Thomason Langworthy Kohn & Van Dyke, P.C. v. Resolution Trust Corporation*, 5 F.3d 1508, 1514-15 (D.C. Cir. 1993) (no to state insured-insurer privilege); *Dowling v. American Hawaii Cruises, Inc.*, 971 F.2d 423 (9th Cir. 1992) (no to state privilege for safety review meetings).

To be sure, petitioners here, as below, purport to rely upon some of these same cases by attempting to distinguish them as being only *apparently* adverse authority. Their theory is that in listed cases where the gravamen was not, at least directly, improper patient care — *e.g.*, antitrust or discrimination cases — discovery notwithstanding the state peer review privilege could be justified because these purported violations happened "in" the peer review process itself, as opposed to the violations merely being analyzed by the peer review process.

This argument is unpersuasive for two reasons. First, regardless of the purported distinction, the upshot is that court after court has ordered discovery of peer review information. No matter what the theory, such discovery obviously is so common that no reasonable doctor could truly have relied on the supposed immunity from discovery of peer review records. Yet this frequent knowledge and fact of discovery has not caused the medical care system to collapse as the petitions say will happen because of the discovery ordered in this case.

Second, as we showed in the Statement of the Case, the purported distinction between those cases and the instant case does not actually exist. Or, even if it does arguably exist, that issue is not fit for review by the Supreme Court.

The *primary* ground for the district court's order, as we explained, was that sufficient evidence supported plaintiff's contention that relevant misconduct *did* happen "in" the peer review process itself. That alone takes the case out of the fact pattern petitioners have invented in their attempt to obtain certiorari. (That pattern, again, is

one where the peer review records contain nothing more than straight commentary by doctors about each other's performance). This determination by the district court was based upon its knowledge of the record in this case, which is a matter especially within its zone of discretion. It probably would not be appropriate for Supreme Court review even on a properly presented appeal after final judgment. It *certainly* is not appropriate for Supreme Court intervention on an interlocutory basis.

B. There Is *No* Intercircuit Split On the Question Whether A Party Who is Not the Target of Discovery In a Civil Case Has The Right to Automatic Appeal Of An Interlocutory Discovery Order Directed At Another Party, Particularly Where the Other Party Is Able and Motivated to Contest the Discovery Order Itself, Whether By Petition for Mandamus, as Has Already Occurred Here, Or Subsequently By Suffering Contempt and Then Appealing the Contempt Ruling.

Although the Hospitals' and Schug's petitions for mandamus were and are unmeritorious, defendants were entitled to bring them and to make their arguments to the Ninth Circuit and to the Supreme Court. Those petitions did not halt all progress in the litigation of the civil suit in the district court. Although the Ninth Circuit issued a stay, which remains in effect, of the order for discovery of the peer review records, that did not prevent any other case proceedings from going forward in the district court.

But Schug's separate appeal was fraudulent misconduct from the beginning, which has now been exacerbated by a fraudulent presentation to this Court of an entirely nonexistent "intercircuit split" in the authority applicable to interlocutory appeals of discovery orders in civil cases. This improper appeal had, and continues to have, precisely the devastating "freezing" effect on the entire civil case, prevention of which is the underlying rationale for the important statutory and case law policy against piecemeal interlocutory appeals. The appeal, unlike the mandamus petitions, caused the case file to be transferred from the district court to the Ninth Circuit, thereby depriving the district court of jurisdiction to move the case forward through remaining motions to a trial date. This freeze has lasted for a year now, and will continue while the certiorari petition as to the appeal is pending.

28 U.S.C. Sec. 1291 gives the courts of appeal jurisdiction over appeals solely from final decisions of district courts, which do not include interlocutory discovery orders. Section 1292(b), however, provides a discretionary avenue to obtain immediate appellate relief from an allegedly oppressive discovery (or other) order: Asking the district court to certify the order for immediate appeal.

Schug omits from his fact statement the crucial information that his trial court law firm did file a motion, including memorandum of law, on June 1, 1998 for Sec. 1292(b) certification of the district court's order. *See* excerpt from district court docket sheet, attached hereto as App. A. However, the attorney in the firm who filed those papers apparently was unaware that a different

attorney in the firm had been told by the district judge at a status conference three days earlier that if such motion were presented, the court would not be inclined to grant it. *See* declaration of respondents' counsel, attached hereto as App. B. This information induced Schug's counsel on June 4, 1998 to withdraw the motion for Sec. 1292(b) certification. *See* App. A.

But instead of the withdrawal's terminating interlocutory appellate proceeding in this case, Schug's counsel, despite obvious awareness that discretionary certification was the proper and sole remedy for immediate relief, replaced their certification motion with a notice of appeal as of right under Sec. 1291. *See* App. A (entry for June 3, 1998). They persist in that improper venture to this very day.

Not a single case cited in Schug's petition (pp. 21-26) supports the theory that a party in a *civil* case has a right to automatic interlocutory of a discovery order that supposedly affects him, but which is directed at another party in the same case who holds the documents and other information sought. Moreover, such interlocutory appeal is particularly inappropriate where, as here, the other party is fully motivated to contest the order and is indeed vigorously contesting the order. Such an appeal, which violates basic black letter federal doctrine against piecemeal appeals, is not supported by *Perlman v. United States*, 247 U.S. 7 (1918), or any other authority.

The Ninth Circuit summarily dismissed the appeal based on its own prior authority, *In re National Mortgage*

Equity Corp., 857 F.2d 1238 (9th Cir. 1988), which explained why neither *Perlman* nor any other case supports a right to appeal a civil discovery order in that situation. This Ninth Circuit decision, however, broke no new ground nor is it contrary to any case from any other circuit.

The Ninth Circuit explained that it, like the Supreme Court and some other circuits, had previously permitted interlocutory appeals by parties who claimed potential adverse impact of disclosures by a third party, one *not* a party to any ongoing civil case, who had been served with a grand jury subpoena. 857 F.2d at 1240, citing *Gravel v. United States*, 408 U.S. 606, 608 n.1 (1972); *In re Grand Jury Proceeding (Schofield)*, 721 F.2d 1221 (9th Cir. 1983); *In re Grand Jury Subpoena Duces Tecum (Marger)*, 695 F.2d 363 (9th Cir. 1982); *In re Gren*, 633 F.2d 825 (9th Cir. 1980); *Harris v. United States*, 413 F.2d 316 (9th Cir. 1969).

The Ninth Circuit also cited, and endorsed, a different basis for immediate appeal "where the aggrieved party's motion or petition is the only pending proceeding in any federal court," a situation that, of course, does not exist where that party opposes a discovery order directed at another party in an ongoing civil case. *See* 857 F.2d at 1240, citing *Eastland v. U.S. Servicemen's Fund*, 421 U.S. 491, 514 (1975) (motion in district court to quash U.S. Senate subpoena directed at third party); *Go-Bart Importing Co. v. United States*, 282 U.S. 344, 356 (1931) (no criminal case pending when motion was made); *Burdeau v. Powell*, 256 U.S. 465 (1921) (same); and several other cases to the same effect.

The Ninth Circuit's opinion cast no doubt on the viability of all these cases as applications of the so-called *Perlman* exception to non-appealability of interlocutory discovery orders or subpoenas, contrary to Schug's preposterous claim that the opinion construes the exception so narrowly that it "essentially eliminates" it. (Schug Pet. 22.) Rather, the Ninth Circuit correctly explained that a case like the instant one is fundamentally different:

> "The reason for allowing [interlocutory] review of such orders in the grand jury context is that there are aspects of independence from the main course of any prosecution that render the order collateral. . . . We are persuaded that any aspect of independence is lost in an ongoing civil case where a party is aggrieved by a district court discovery order. The essential character of any litigation over a discovery order and the circumstances under which the order is issued, as in this case, render it merely a step in the civil proceeding." 857 F.2d at 1240.

All the cases cited in Schug's petition, from every circuit, are entirely consistent with the Ninth Circuit's endorsement of immediate appealability (the "*Perlman* exception") in the instances described, while recognizing that its rationale does not extend to discovery orders directed at civil litigation parties. The most thorough explanations are two First and Second Circuit opinions that Schug cites for some peculiar reason, even though they definitively reject his precise argument for automatic right of appeal.

In *Corporacion Insular De Seguros v. Garcia*, 876 F.2d 254 (1st Cir. 1989), the court explains why it *rejected* a party's claim that the *Perlman* case gave him the right to

appeal a discovery order directed at another party. *Id.* at 258-59. The First Circuit relied upon Judge Friendly's opinion in *National Super Spuds, Inc. v. New York Mercantile Exchange*, 591 F.2d 174, 178 (2d Cir. 1979), the other case cited by Schug.

Judge Friendly gave perhaps the most thorough explanation extant of why the *Perlman* case has nothing to do with discovery orders in civil cases. The point is very simple, but Schug muddles it by making a crucial error in describing the key facts in *Perlman*.

Schug's petition claims the grand jury subpoena to which Mr. Perlman objected was directed at his "bookkeeper." Schug Pet. 22. The implication is that even though the bookkeeper was not a party to ongoing civil litigation, the situation was sufficiently similar to the relationship between doctor and hospital that if Perlman could take an interlocutory appeal, despite that he was not the target, then so should Schug.

But the subpoena was *not* directed at Perlman's "bookkeeper"! Rather, it was directed at the clerk of the U.S. District Court in New York who was holding some sensitive documents of Perlman's company that had been exhibits in a prior proceeding. 247 U.S. at 8-10. *The whole point of the Perlman case was that a subpoena directed to such a completely uninvolved and obviously unmotivated and disinterested third party created a special situation because such person would have no wish or motive to contest it on behalf of the party who might be injured by the disclosure.* That is why the First Circuit in *Corporacion Insular*, and Judge Friendly in *National Super Spuds*, distinguished *Perlman* "as a 'unique case' in which there was no relation between the

holder of the privilege (Perlman) and the target of the court's order (the clerk of the district court)." 876 F.2d at 259; 591 F.2d at 180.[2]

In sharp contrast, where a relationship — whether of employment, self-interest, or otherwise — does exist, the target of the subpoena "may reasonably be expected to risk a contempt citation in order to preserve both his own and his employer's right to appellate review of their joint claim of privilege." 876 F.2d at 260. Judge Friendly expounded at greater length to the same effect. *See* 591 F.2d at 179-180.

These opinions, though they do not cite it, were in fact following the Supreme Court's decision in *United States v. Ryan*, 402 U.S. 530 (1971). This Court explained that the basic rationale of *Perlman* was that "the custodian [of Perlman's records] could hardly have been expected to risk a citation for contempt in order to secure Perlman an opportunity for judicial review." *Id.* at 533.

That situation is so far removed from the instant case as to render Schug's petition on the appeal simply absurd. It would be difficult to imagine a more motivated and effective subpoena or discovery order target, both in theory and in fact, than the Hospital petitioners herein. In theory, because they obviously have an even broader and

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[2] The court in *Corporacion Insular* also explains why Schug's citation to *Nixon v. Sirica*, 487 F.2d 700, 707 (D.C. Cir. 1973), is irrelevant. The reason, of course, is the obvious one: "But *Nixon* was a unique case, and we do not believe that the court meant to extend it to any government official other than the President himself." 876 F.2d at 257, citing *In re Attorney General of the United States*, 596 F.2d 58, 62 (2d Cir. 1979).

more profound claimed interest than Schug in the confidentiality of their records. He alleges potential embarrassment to himself alone. But no matter how bad that might be, it hardly can compare with the Hospital's sweeping claim that discovery will destroy the entire system of peer review that it alleges is fundamental to its services.

The Hospital also is motivated and effective *in fact* because it has indeed vigorously pursued its mandamus petition, sparing no effort or legal expense. Whether it will suffer contempt in order to obtain further appellate review (on a *legitimate* basis this time) remains to be seen. But Dr. Schug cannot plausibly say that the Hospital is less than fully motivated and capable of doing so.

All of Schug's remaining citations similarly fail to support either his substantive argument or his argument for certiorari based on purported intercircuit conflict. We dispose of them briefly.

Boughton v. Cotter Corp., 10 F.3d 746 (10th Cir. 1993), is perhaps Schug's strangest citation because its flat rejection of interlocutory appeal of the discovery order in that civil case is entirely consistent with the Ninth Circuit's same holding in *In re National Mortgage Equity Corp., supra*, and thus in the instant case as well. The courts cite numerous other cases, also consistent with the Ninth Circuit, noting that "in virtually every case in other circuits involving similar attorney-client privilege claims, the courts have refused to take [appellate] jurisdiction." 10 F.3d at 749-50.

Even more remarkably, the Tenth Circuit in *Boughton* delivers the coup de grace to Schug's misconceived theory that the *Perlman* exception permits his immediāte appeal. The court observed that defendants there did "not [even] rely on *Perlman* and deny application of these [grand jury subpoena cases], arguing that they involve grand jury criminal investigations"! *Id.* at 749-50 n.2. Schug's attorneys should have had the integrity to take the same position instead of vainly pursuing their improper appeal.

In re Grand Jury Investigation of Ocean Transportation, 604 F.2d 672 (D.C. Cir. 1979), was not only a grand jury case just like those distinguished by the Ninth Circuit, and every other circuit, from ongoing civil litigation, but the privilege, even if it had once existed, had been effectively waived. *In re Faltico*, 561 F.2d 109 (8th Cir. 1977), similarly involved a grand jury subpoena directed at a non-party "who could not be expected to expose himself to the penalty of contempt in order to obtain appellate review," precisely because his non-party status gave him no particular stake in the litigation or interest in the aggrieved party's complaint about the discovery. *Schwimmer v. United States*, 232 F.2d 855, 860 (8th Cir. 1956), was by Schug's own description a similar grand jury subpoena directed at non-party with no interest in resisting it. Similarly, all the cases cited in footnotes 30, 31, 32, and 36 of Schug's petition (p. 24) are also grand jury subpoena cases, are entirely consistent with the Ninth Circuit's decision on which dismissal of the instant appeal was based, and are thus irrelevant because they establish no "intercircuit conflict."

The subpoena in *Covey Oil Co. v. Continental Oil Co.*, 340 F.2d 993 (10th Cir. 1965), was indeed issued in a civil case, but it went to a non-party witness. Schug overlooks that this makes that case quite different from the instant case. The non-party target of the subpoena there was the very one who brought the appeal, unlike Schug who claims the right to appeal even though he is *not* the target of the discovery. *Id.* at 996. It was the combination of being both a non-party and the target that created the right to appeal: "The appellants, as nonparties to the main suit, will have no right to appeal from a judgment therein. The trial court's order [will be] final as to these appellants." *Id.*

Finally, *Branch v. Phillips Petroleum Co.*, 638 F.2d 873, 877-78 (5th Cir. 1981), is irrelevant because it involved the distinguishable situation of the Government's special right to interlocutory appeal in some discovery contexts.

Accordingly, the law on the appeal matter is settled, it is consistent throughout the nation, there certainly is no "intercircuit conflict," and Schug's argument in this part of his petition is utterly without merit, either as to worthiness for certiorari or as to legal substance.

III.

CONCLUSION

For the reasons given above, the petitions for certiorari should be denied.

Dated: May 5, 1999

Respectfully submitted,

LAW OFFICES OF JAMES BRADEN

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Counsel for Respondents

APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

DAVID BURROWS, et al. Plaintiff(s), (Petitioner) v. REDBUD COMMUNITY HOSPITAL DIST., et al. Defendant(s), (Respondent)	Court of Appeals Docket No. 98-70610 Docket Number(s) of Court of Appeals Companion and/or Cross Appeals (if known) 98-70616 District Court Docket Number C 96-4345 SI Date Transcript(s) Filed: no transcripts designated

CERTIFICATE OF RECORD

This certificate is submitted in conformance with Rule 11-2 of the Local Rules of the U.S. Court of Appeals for the Ninth Circuit. The record on appeal, consisting of the trial transcript (if any) and the trial court clerk's record, is ready for the purposes of the appeal. This record is available in the Clerk's Office of the U.S. District Court identified below.

The documents comprising the trial court clerk's record have been numbered in conformance with Rule 11(b) of the Federal Rules of Appellate Procedure. These document numbers are reflected on the U.S. District Court docket sheet and should be used for reference purposes in the briefs.

The actual filing date for this document in the U.S. Court of Appeals will initiate the briefing schedule in civil cases (including habeas corpus cases). All parties in civil cases will receive separate notification of this filing date. In criminal cases, the briefing schedule is set by a Time Schedule Order from the U.S. Court of Appeals.

DATED: July 16, 1998

Office of the
Clerk
U.S. District Court
Northern District of
California
450 Golden Gate
Ave., Box 36060
San Francisco, CA 94102

RICHARD W. WIEKING
CLERK

/s/ Cora G. Delfin

by: Cora Delfin
Deputy Clerk

Proceedings include all events.
3:96cv4345 Burrows, et al. v. Redbud Community Hos, et al.

APPEAL

6/1/98 161 ***NOTICE by defendant Dr. Wolfgang Schug's request for certification of order for appeal. [3:96-cv-04345] (cgd) [Entry date 06/03/98]***

6/1/98 162 ***MEMORANDUM OF POINTS AND AUTHORITIES by defendant Wolfgang Schug in support of notice [161-1] [3:96-cv-04345] (cgd) [Entry date 06/03/98]***

6/3/98 163 LETTER dated 6/1/98 from John S. Gilmore for Adventist Health Inc in response to letter from plaintiff's counsel dated 5/26/98. [3:96-cv-04345] (cgd) [Entry date 06/05/98]

6/3/98 164 LETTER dated 6/2/98 from Redbud Community Hospital District in response by plaintiff's attorney, Richard Massa dated 5/26/98. [3:96-cv-04345] (cgd) [Entry date 06/05/98]

6/3/98 165 MINUTES: (C/R N/A) (Hearing date: 5.29.98) Further case management conference – Held. Motion for leave to file amended complaint – Submitted. Discovery cutoff extended to 7/24/98; Expert Discovery cutoff extended to 6/26/98. Motion for leave granted and plaintiff to file amended complaint next week; request for order shortening time submitted; Defendants to respond to submitted letter not later than 6/2/98. Court to issue order re 1157 issues; Defendants request for one

[Boldface emphasis added by respondents]

week continuance for expert disclosure granted. [3:96-cv-04345] (cgd) [Entry date 06/05/98]

6/3/98 171 ***NOTICE OF APPEAL by defendant Wolfgang Schug, M.D., defendant JJ&R Emergency Mgmt (sued erroneously as Emergency Medical Management Services, Inc. from Dist. Court decision order dated 5/5/98 [154-1] Fee status Paid, $105.00, receipt no. 131499. [3:96-cv-04345] (cgd) [Entry date 06/08/98]***

6/4/98 166 LETTER dated 6/1/98 from Richard J. Massa re possible use of jury instructions discussed at the case mgmt conf. on 5/29/98. [3:96-cv-04345] (cgd) [Entry date 06/05/98]

6/4/98 167 LETTER dated 6/2/98 from Matthew P. Miller re discovery disputes. [3:96-cv-04345] (cgd) [Entry date 06/05/98]

6/4/98 168 LETTER dated 6/3/98 from Sonja M. Dahl to Mr. Massa. [3:96-cv-04345] (cgd) [Entry date 06/05/98]

6/4/98 169 LETTER dated 6/4/98 from Thomas J. Donnelly for Redbud Community Hospital re a petition for writ be filed with the Appellate Court regarding the Evidence Code 1157 issues. [3:96-cv-04345] (cgd) [Entry date 06/05/98]

6/4/98 170 ***NOTICE by defendant of withdrawal of request for certification. [3:96-cv-04345] (cgd) [Entry date 06/05/98]***

Docket as of July 16, 1998 11:47 a.m.

[Boldface emphasis added by respondents]

APPENDIX B

MASSA & ASSOCIATES

Attorneys At Law
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Lakeport, California 95453

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January 15, 1999

DECLARATION OF RICHARD J. MASSA

I, RICHARD J. MASSA, declare:

I am an attorney at law admitted to practice before the United States District Court for the Northern District of California and the Ninth Circuit Court of Appeals, am the attorney of record and primarily responsible for filing, preparation and trial of the case of *Burrows, et al., v. Redbud Hospital, et al.*, No. C-96-4345 SI, in the United States District Court, Northern District of California.

I have been personally present at every hearing and conference held on this matter in the trial court, specifically including the Case Management Conference of May 29, 1998, held before the Honorable Susan Illston, District Judge.

At no time during the May 29, 1998, Case Management Conference, or at any other time, in my presence or to my knowledge, did Judge Illston "instruct" defendant SCHUG, et al., or counsel for defendant SCHUG, et al., to "withdraw" a request for certification of any order for appeal.

With regard to the Case Management Conference held in this matter on May 29, 1998, the only relevant

comment of Judge Illston with regard to this matter that declarant recalls was to the effect that if a request for certification were to be made, the Court would not be inclined to grant such a request.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

DATED: January 15, 1999 /s/ Richard J. Massa
RICHARD J. MASSA

MOTION FILED
MAY 5 1999

(3) (4)

Nos. 98-1513 and 98-1526

In The

Supreme Court of the United States

REDBUD COMMUNITY HOSPITAL,
ADVENTIST HEALTH, INC.,

Petitioners,

vs.

UNITED STATES DISTRICT COURT, NORTHERN DISTRICT OF CALIFORNIA, DAVID BURROWS, RHODA THOMAS,

Respondents.

and

WOLFGANG SCHUG, M.D.,

Petitioner,

vs.

DAVID BURROWS, successor-in-interest to Cody Burrows, deceased; DAVID BURROWS and RHODA THOMAS individually and as heirs and surviving parents of Cody Burrows,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

MOTION FOR LEAVE TO FILE BRIEF AND BRIEF OF AMICI CURIAE CALIFORNIA MEDICAL ASSOCIATION, CALIFORNIA HEALTHCARE ASSOCIATION, CALIFORNIA ACADEMY OF FAMILY PHYSICIANS, AMERICAN MEDICAL ASSOCIATION, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS AND ITS CALIFORNIA CHAPTER, AND JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS IN SUPPORT OF PETITIONS FOR WRIT OF CERTIORARI

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May 1999

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MOTION FOR LEAVE TO FILE BRIEF AS *AMICI CURIAE* AND *AMICI CURIAE BRIEF* IN SUPPORT OF PETITIONS FOR WRIT OF CERTIORARI

The California Medical Association, the California Healthcare Association, the California Academy of Family Physicians, the American Medical Association on its own behalf and on behalf of the 45 state medical associations which comprise the American Medical Association/ State Medical Society Litigation Center, the American College of Emergency Physicians and its California Chapter, and the Joint Commission on Accreditation of Healthcare Organizations (*"amici"*) hereby respectfully move for leave to file the attached brief of *amici curiae* in support of petitioners' Petitions for Writ of Certiorari in this case. The consent of the attorneys for the petitioners have been obtained. Respondents have refused to consent. The letters of consent we did receive have been filed separately with the court in this case.

All of *amici* are committed to, among other things, assuring the quality of health care in this country. The interest of *amici* in this case arises from the fact that the holdings below threaten confidentiality protections for peer review records and proceedings, and therefore threaten the quality of health care delivered in this country. Medical peer review is essential to assure physicians and other health care providers deliver quality health care and is interwoven throughout the health care licensing and accreditation standards, such as those promulgated by *amicus* Joint Commission and Accreditation of Healthcare Organizations. Any holding that fails to apply confidentiality protections for records or proceedings of

medical peer review bodies threatens to chill the willingness of practitioners to become involved in the evaluative process so essential to successful peer review.

Amici move for leave to file this brief in support of the Petition for Writ of Certiorari in order to more fully describe the medical peer review system in operation throughout the nation and highlight the potential crippling effects the lower court's ruling will have, if left to stand, on its successful functioning.

Respectfully submitted,

CATHERINE I. HANSON
Attorney for:
California Medical Association
California Academy of Family Physicians
California Healthcare Association
American College of Emergency Physicians and its California Chapter
American Medical Association on its own behalf and on behalf of 45 State Medical Associations
Joint Commission on Accreditation of Healthcare Organizations

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BRIEF OF *AMICI CURIAE*

This brief of *amici curiae*[1] is filed in support of the Petition for Writ of Certiorari filed by Wolfgang Schug, M.D., Redbud Community Hospital and Adventist Health, Inc. and is submitted on behalf of the California Medical Association, the California Healthcare Association, the California Academy of Family Physicians, the American Medical Association and the forty-five state medical associations and societies that are members of the AMA State National Society Litigation Center, the American College of Emergency Physicians and its California chapter, and the Joint Commission on Accreditation of Healthcare Organizations (herein referred to collectively as *"amici"*).

INTEREST OF *AMICI CURIAE*

The California Medical Association (CMA) is a nonprofit incorporated professional association of more than 30,000 physicians practicing in the state of California. CMA's membership includes most of the California physicians who are engaged in the private practice of medicine,

[1] All the parties except Respondents have consented to the filing of this brief. The letters of consent from all of the Petitioners have been filed with the Clerk of the Court. Counsel for a party did not author this brief in whole or in part. A draft of the brief was submitted to counsel for petitioner Wolfgang Schug, M.D., for review and comment. No person or entity, other than the *amici curiae*, their members, or their counsel made a monetary contribution to the preparation and submission of this brief.

in all specialties. The CMA's primary purposes are: " . . . to promote the science and art of medicine, the care and well-being of patients, the protection of the public health, and the betterment of the medical profession. . . . "

The California Healthcare Association (CHA) is a non-profit trade association representing more than 540 hospitals. CHA membership includes public, private, non-profit and proprietary hospitals which are required by law to maintain medical staffs which engage in peer review. CHA is dedicated to serving the public's health care needs.

The California Academy of Family Physicians (CAFP) is a medical specialty society with more than 6,800 members. The mission of CAFP is to enhance, strengthen, and promote the specialty of family medicine, to promote professional and personal growth for its members, and to advocate for family centered care for all Californians. Family physicians are residency-trained primary care specialists who are able to treat a wide variety of illnesses and conditions and coordinate the care their patients receive from other physicians. Family physicians play an essential role in today's health care system, and are more likely to locate their practices in urban or rural underserved areas than physicians in other medical specialties.

The American College of Emergency Physicians (ACEP) is the largest national professional organization representing the specialty of emergency medicine with more than 19,800 members. ACEP exists to support quality emergency medical care and to promote the interests of emergency physicians. The California Chapter of ACEP ("CAL/ACEP") is by far the largest state chapter

of emergency physicians with almost 2000 members practicing in approximately 400 hospitals.

The American Medical Association (AMA), a nonprofit corporation, is an association of approximately 275,000 physicians who practice throughout the United States. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health, and these still remain its core purposes. Its members practice in all fields of medical specialization, and it is the largest medical society in the United States.

The AMA files this brief as a representative of the American Medical Association/State Medical Society Litigation Center ("Litigation Center"). The Litigation Center was formed in 1995 as a coalition of the AMA and private, voluntary, nonprofit state medical societies to represent the views of organized medicine in the courts. Forty-five state medical societies join the AMA as members of the Litigation Center. The member organizations, in addition to the AMA, are: Medical Association of the State of Alabama, Alaska State Medical Association, Arkansas Medical Society, California Medical Association, Colorado Medical Society, Connecticut State Medical Society, Medical Society of Delaware, Medical Society of the District of Columbia, Florida Medical Association, Medical Association of Georgia, Hawaii Medical Association, Illinois State Medical Society, Indiana State Medical Association, Iowa Medical Society, Kansas Medical Society, Kentucky Medical Association, Louisiana State Medical Society, Maine Medical Association, Massachusetts Medical Society, Michigan State Medical Society, Minnesota Medical Association, Mississippi State Medical Association, Missouri State Medical Association, Montana

Medical Association, Nebraska Medical Association, New Hampshire Medical Society, Medical Society of New Jersey, New Mexico Medical Society, Medical Society of the State of New York, North Carolina Medical Society, North Dakota Medical Association, Ohio State Medical Association, Oklahoma State Medical Association, Oregon Medical Association, Pennsylvania Medical Society, Rhode Island Medical Society, South Carolina Medical Association, Tennessee Medical Association, Texas Medical Association, Utah Medical Association, Vermont State Medical Society, Washington State Medical Association, West Virginia State Medical Association, State Medical Society of Wisconsin, and Wyoming Medical Society.

The Joint Commission on Accreditation of Healthcare Organizations ("JCAHO" or "Joint Commission") is the leading health care accrediting body in the world, evaluating and accrediting nearly 20,000 health care organizations and programs in the United States. An independent, not-for-profit organization, the Joint Commission is the nation's predominant standards-setting and accrediting body in health care. Since its founding in 1951, the Joint Commission has had one basic purpose: to improve the quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations. The Joint Commission accredits almost 11,000 of the nation's hospitals and home health agencies, and more than 7,000 other health care organizations, including health care networks, clinical laboratories and ambulatory care, long term care and behavioral health care organizations. For more than four decades, the Joint Commission has developed state-of-the-art standards and

evaluated the compliance of health care organizations against them.

A. *Amici* CMA, CHA, CAFP, CAL/ACEP, AMA, ACEP and JCAHO Urge this Court to Grant the Petition for Writ of Certiorari in This Case.

Amici strongly support the petition in this case because it raises an issue of profound importance: the preservation of the system of confidential medical peer review which functions in every state in the nation to provide significant protection of the public health. This Court should grant review to create a federal medical peer review immunity, or in the alternative require as a matter of comity that deference always be granted to state-created peer review privileges in civil lawsuits alleging EMTALA or other violations of the standard of care. Discovery of medical peer review records must be prohibited in such cases, whether cloaked under EMTALA or other federal statutes, to assure the nations' system of medical peer review is not crippled by a loss of confidentiality. Such a ruling would also reduce the likelihood of plaintiffs forum shopping what are in essence medical malpractice cases recast under federal theories.[2]

In state courts, statutes like that at issue in this case, California Evidence Code Section 1157 ("Section 1157"),

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[2] *See, e.g. Barris v. County of Los Angeles*, 20 Cal. 4th 101, 83 Cal.Rptr. 2d 145 (1999) in which the California Supreme Court ruled that an EMTALA claim based on a failure to stabilize a patient's emergency medical condition, is "based on professional negligence" and thus subject to California's Medical Injury and Compensation Reform Act like any other case alleging medical malpractice.

prohibit civil discovery of medical peer review records. Section 1157 protects peer review information from disclosure through civil discovery as do similar state statutes throughout the nation. Creation of a federal medical peer review privilege against discovery, or a ruling requiring deference to state-created protections based on principles of comity, is absolutely necessary to avoid irreparable harm to the profoundly important public policy uniformly mandated by virtually all of the 50 state legislatures,[3] namely, that the confidentiality of the medical peer review system in operation throughout the country be protected. The protection of that system, and the crucial quality improvement functions it performs in the nation's hospitals and other health facilities, requires that records falling within the ambit of immunity statutes like Section 1157 not be subject to compelled disclosure in any civil proceedings, however denominated, challenging the quality of medical care provided.

B. Permitting Compelled Disclosure of Medical Peer Review Records in EMTALA Claims Would Profoundly Chill the Nation's Physicians' Willingness to Participate Candidly in Peer Review With Little or No Countervailing Benefit to the Search for Truth.

With at least the perception among members of the medical profession that increasing numbers of EMTALA

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[3] Recent case law in Kentucky appears to have diminished the confidentiality protections for peer review records and proceedings embodied in that state's peer review statute. *See Sisters of Charity Health Systems, Inc. v. Raikes (Dones)*, 984 S.W.2d 464 (1998).

cases are being filed,[4] the chilling effect the threat of compelled disclosure of peer review records in such cases on physicians' willingness to participate in candid and meaningful peer review becomes ever more pronounced. Physician participation as medical peer reviewers on hospital medical staffs and in other settings is generally an entirely volunteer endeavor, affording no additional pay, sometimes incurring lost income for time taken from practice, and offering little tangible reward other than the knowledge that the profession and patient safety are enhanced by continuous and rigorous peer review. Disclosure of peer review records for purposes of federal EMTALA cases (and any pendent state claims) raises the specter that peer review records containing candid critiques by identifiable physician reviewers will be placed into evidence for the world to see. The reluctance of physicians to "serve up" their hospitals and peers in this way is obvious and profound, particularly given the potential such information will be taken out of the collegial and constructive context in which it was offered, whether by the plaintiffs' attorneys or the subject physician. Indeed, notwithstanding broad immunities from liability for peer review communications, lawsuits brought by the affected health care providers are not unheard of when confidential communications are made public.[5] Such disclosures may also cause discord between people

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[4] *See, e.g., Roberts v. Galen of Virginia, Inc.*, 525 U.S. ___, 142 L.Ed.2d 648 (January 13, 1999) (Recovery for violation of EMTALA provision (42 U.S.C. § 1395dd(b)) held not to require proof that hospital acted with improper motive in failing to stabilize patient.)

[5] *See, e.g., Dorn v. Mendelzon*, 196 Cal.App.3d 933, 242 Cal.Rptr. 259 (1987).

who may of necessity continue working together very closely. Further, in the absence of a discovery immunity, more plaintiffs would seek to depose or call physician reviewers themselves to trial, adding further to the chilling effect on physician participation in the various states' medical peer review systems.

There is no countervailing evidentiary benefit which would justify this disruption. Peer review records sought by plaintiffs in cases challenging the quality of medical services provided are created by an evaluative process performed after-the-fact. In these cases, application of the immunity statute to prohibit access to peer review records does nothing to preclude plaintiffs' own evaluation of the evidence they gather elsewhere through discovery, such as the medical records. To deny the requested discovery is in no way inconsistent with Congress' goals in enacting EMTALA, or with other federal policy.

The public policy supporting the discovery immunity for medical peer review is thus far stronger than it was for the academic peer review at issue in *University of Pennsylvania v. Equal Employment Opportunity Commission*, 493 U.S. 182, 107 L.Ed. 2d 571 (1990). In cases alleging discriminatory faculty tenure decisions, the faculty peer review information may often be the best, if not the only evidence available to prove the claim. *See University of Pennsylvania v. EEOC*, 493 U.S. at 193; 107 L.Ed. 2d at 584-585. On the other hand, medical peer review information will be, at most, a potential source of secondary evidence in EMTALA and similar cases which do not challenge the fairness of the peer review process itself. Medical peer review information in such cases is much more like the after-the-fact psychotherapy records this

Court protected from discovery in *Jaffee v. Redmond*, 518 U.S. 1, 135 L.Ed. 2d 337 (1996). Indeed, this Court's admonition in the *Jaffee* case is equally applicable with respect to medical peer review: "[w]ithout a privilege, much of the desirable evidence to which litigators . . . seek access . . . is unlikely to come into being." *Jaffee v. Redmond*, 135 L.Ed. 2d at 346.

C. The Strong Public Policy Considerations Favoring Open and Candid Medical Peer Review Would Be Severely Frustrated if the States' Various Peer Review Immunity Statutes Could Be Bypassed by Filing in Federal Court.

Statutes like California Evidence Code Section 1157 promote important public policy considerations. Specifically, they reflect a recognition of two essential truths: (1) that diligent performance of medical quality assessment and peer review is essential to the public health, and (2) that medical quality assessment and peer review will fail in the absence of confidentiality. *See, e.g., Matchett v. Superior Court*, 40 Cal.App.3d 623, 115 Cal.Rptr. 317 (1974). In *Matchett*, a California appellate court noted the critical need for medical staff peer review committees in protecting the public by policing the profession, and supported the rationale for the discovery immunity stating:

> In an accredited hospital, the organized medical staff is responsible to the hospital governing body for the quality of in-hospital medical care; it evaluates the qualifications of applicants and holders of staff privileges; it recommends appointment, reappointment, curtailment and exclusion from staff privileges; it provides peer group methods for reviewing basic medical,

> surgical and obstetrical functions. [citations omitted] . . . [T]he quality of in-hospital medical care depends heavily upon the committee members' frankness in evaluating their associates' medical skills and their objectivity in regulating staff privileges. Although composed of volunteer professionals, these committees are affected with a strong element of public interest.
>
> * * *
>
> ***Section 1157 was enacted upon the theory that external access to peer investigations conducted by staff committees stifles candor and inhibits objectivity.*** It evinces a legislative judgment that the quality of in-hospital medical practice will be elevated by armoring staff inquiries with a measure of confidentiality.

Matchett, supra, 40 Cal. App. 3d at 628-29; emphasis added.

The *Matchett* court thus found that:

> Section 1157 represents a legislative choice between competing public concerns. It embraces the goal of medical staff candor at the cost of impairing plaintiffs' access to evidence.

Matchett, supra, 40 Cal.App.3d at 629.

Courts have repeatedly reaffirmed the need for medical peer review discovery immunities to insure that medical peer review be conducted with full candor, without the chilling threat of potential discovery of the peer review proceedings. For example, in *Alexander v. Superior Court,* 5 Cal.4th 1218, 23 Cal.Rptr.2d 397 (1993), the California Supreme Court noted that allowing discovery of peer review information submitted to medical staff committees from outside physicians would be detrimental to patients. As the Court stated:

> The immediately predictable result will be that physicians . . . will cease providing . . . negative information or constructive criticism. . . . Without this frank exchange of information, medical staffs will have no legal grounds upon which to initiate corrective action (such as restricting privileges or requiring monitoring or further education) that could be critical to the protection of patients. Clearly such a result would be contrary to the Legislature's intent in enacting Section 1157.

Alexander v. Superior Court, 5 Cal.4th at 1227-28, 23 Cal.Rptr.2d at 403.

The need to protect the confidentiality of medical peer review records from compelled discovery in civil litigation has also been recognized by federal courts. As discussed in the leading federal case recognizing a privilege for medical peer review:

> Confidentiality is essential to effective functioning of these staff meetings; and these meetings are essential to the continued improvement in the care and treatment of patients. Candid and conscientious evaluation of clinical practices is a *sine qua non* of adequate hospital care. . . . Constructive professional criticism cannot occur in an atmosphere of apprehension that one doctor's suggestion will be used as a denunciation of a colleague's conduct in a malpractice suit.

Bredice v. Doctors Hospital, Inc., 50 F.R.D. 249 (D.D.C. 1970), aff'd, 479 F.2d 920 (D.C. Cir. 1973). *See also Weekoty v. United States*, 30 F.Supp.2d 1343 (D.N.M.) 1998.

These decisions are informed by the conclusion of Legislatures throughout the country that a comprehensive, ongoing system of rigorous medical peer review is

necessary to the health and welfare of the people of this nation. Indeed, such activity is a principal patient protection mechanism in hospitals throughout the country. A comprehensive quality assurance process is critical to the identification and resolution of potential or ongoing problems, as well as to the identification of opportunities to improve patient care. Protocols and procedures must be continuously analyzed and revised to reflect new information and technologies. Current assessment of the clinical performance of physicians and other health care providers is crucial in order to provide appropriate education and training where warranted and to identify impaired or deficient individuals *before* patients are injured.

To be effective, this review function must be performed by individuals who have the expertise necessary to evaluate the quality of medical care provided and the ability to implement remedial action in a timely manner. An effective medical peer review system provides the optimal solution. Members of medical staffs have both the expertise and familiarity with the facilities, physicians and other health care providers involved necessary to ferret out problems and take corrective action. With the promise of confidentiality, physicians and other health care providers under review are also free to explain their perspectives on problem cases and contribute to a constructive dialogue.

Thus, like many states, the California Legislature and the Department of Health Services (DHS) require, as a condition of licensure, that each California hospital have an organized, self-governing medical staff, which is responsible for performing a number of quality assurance functions. (Business and Professions Code § 2282; Health

& Safety Code § 1250; 22 California Code of Regulations ("C.C.R.") §§ 70701(a)(1)(F), 70703(a).) Medical peer review is thus crucial in three major areas: (1) credentialing, (2) quality assessment, and (3) ongoing corrective action.

1. **Credentialing.** The medical staff is responsible for protecting the quality of patient care through the credentialing of medical staff applicants and members. Credentialing is a process through which the training and experience of applications/reapplicants for clinical privileges are scrutinized in order to assure the initial and on going competence of every physician, dentist, podiatrist and, in some cases, clinical psychologist who is granted privileges to practice in the hospital, *See generally, Unterthiner v. Desert Hospital District*, 33 Cal.3d 285, 188 Cal.Rptr. 590 (1983). In California, this process must include "formal procedures for the evaluation of staff applications and credentials, appointments reappointments, assignment of clinical privileges, appeal mechanisms and such other subjects or conditions which the medical staff and governing body deem appropriate." 22 C.C.R. § 70703(b). Furthermore, these credentialing procedures msut be:

> [D]esigned to ensure the achievement and maintenance of high standards of professional ethical practices including provision that all members of the medical staff be required to demonstrate their ability to perform surgical and/or other procedures competently and to the satisfaction of an appropriate committee or committees of the staff, at the time of original application for appointment to the staff and at least every two years thereafter. (22 C.C.R. § 70701(a)(7).)

2. **Quality Assessment.** Equally important as its credentialing responsibility is the medical staff's responsibility to continuously monitor the quality of care rendered in the hospital. California hospital licensing regulations specifically require that the medical staff maintain one or more committees formally organized to monitor the care and treatment rendered to hospitalized patients. (22 C.C.R. § 70203(d).) For example, the medical staff is obligated to perform the following patient care review functions on a regular basis:

a. **Medical Records Review:** the evaluation of medical records for their timely completion and adequate reflection of the patient's condition and treatment which is necessary to ensure that others will be able to assume the patient's care if required. (22 C.C.R. §§ 70703(d), 70749 and 70751.)

b. **Surgery Review:** the evaluation of surgeries performed to determine whether the surgery was both indicated and properly executed. (22 C.C.R. §§ 70703(d) and 70223(b),(h).)

c. **Utilization Review:** the evaluation of the allocation of the hospital's health care resources to monitor and address overutilization, underutilization and inefficient scheduling. (22 C.C.R. § 70703(d).)

d. **Infection Control and Antibiotic Usage Review:** the evaluation of the clinical use of antibiotics and the ongoing prevention, surveillance, and control of infections from whatever source, throughout the hospital. (22 C.C.R. §§ 70703(d) and 70739.)

e. **Pharmacy and Therapeutics Review:** the evaluation of pharmacy and therapeutics

practice and the development of a drug formulary and policy relating to the safe handling, distribution, and administration of drugs. (22 C.C.R. §§ 70703(d) and 70263.)

f. Interdisciplinary Practice Committee: the development of written "standardized procedures" and supervision requirements which permit nurses and physicians' assistants to perform extended functions in the hospital. (Business and Professions Code § 2725; 22 C.C.R. §§ 70706 *et seq.*)

g. Clinical Laboratories/Radiology/Anesthesiology Review: the evaluation and the development of procedures governing clinical laboratory, radiology and anesthesiology practice. (22 C.C.R. §§ 70233, 70243, and 70253.)

h. Disaster Planning: the development of a written disaster and mass casualty program. (22 C.C.R. § 70741.)

i. Hospital Safety Planning: the development of a written program to deal with internal disasters such as fires. (22 C.C.R. §§ 70743, 70745 and 70746.)

j. Continuing Education: the development of and participation in a mandatory, ongoing program of continuing education addressing the problems discovered during the foregoing patient care review activities. (22 C.C.R. § 70703(g).)

3. **Corrective Action.** The medical staff also engages in ongoing monitoring of each medical staff member and takes appropriate action, where necessary, to correct or address any problems which might pose a danger to patients. Thus, if in the course of its credentialing or

patient care review activities, the medical staff has reason to believe that a medical staff member may pose a danger to patients, the medical staff will conduct an investigation. Appropriate medical staff departments or committees, including committees with special expertise in dealing with substance abuse or physical or mental impairment, are generally readily available to provide appropriate education or other rehabilitation. In the vast majority of cases, this process allows the medical staff to identify and resolve problems before any patient harm occurs. Where such intervention is not successful, or the medical staff is otherwise of the opinion that the physician or other health care provider should have his or her privileges to practice in the hospital restricted or revoked, a formal hearing process is typically necessary.

These activities, and by implication the necessity of the discovery immunity, are aptly described by one California appellate court as follows:

> These committees perform investigations of physicians applying for staff privileges, establish standards and procedures for patient care, audit each surgery performed, and investigate discrepancies between preoperative and postoperative diagnoses. *The committees compile records and evaluations and engage in frank discussions about the performance and competence of their peers.* Should the committee find a peer to be incompetent, a report and recommendation is made to administrators, who may then take action to revoke, limit, or deny medical staff privileges.

California Eye Institute v. Sup. Ct., 215 Cal.App.3d 1477, 264 Cal.Rptr. 83 (1989), quoting Comment, 24 *Santa Clara L. Rev.* 661, 670, emphasis added.

California is not unique in its recognition and use of comprehensive medical staff quality assurance programs as outlined above. While this is the system in place in the state in which this case arose, similar laws, regulations, or accreditation standards mandate similar peer review activity in most of the nation's hospitals. Indeed, the standards established for the accreditation of hospitals nationally by the Joint Commission impose virtually identical requirements for medical peer review. *See* JCAHO *Comprehensive Accreditation Manual for Hospitals* (1999). Similar peer review activities are also mandated by Congress as a condition for payment under Medicare (42 U.S.C. § 1395x (e) and (k)) and Medicaid (42 U.S.C. § 1396a(a)(9)(A), (19), (26)).

It is important to note that organized medical staff peer review, as prescribed in the JCAHO Standards and as accomplished in California and throughout the nation, was initiated as a *voluntary* activity.[6] The present JCAHO program began as a physician-sponsored effort, under the auspices of the American College of Surgeons, in 1918. Then, as now, the purpose of this activity has always been "the right care of the sick and the injured." Then, as now, the vast majority of medical peer reviewers devote untold

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[6] Nor is medical peer review limited to the hospital setting. Professional medical associations such as those participating as *amici* in this case also engage in medical peer review activity of critical importance to the delivery of quality health care, especially with respect to medical care provided in outpatient facilities or other situations in which the hospital medical staff is unable to provide appropriate review and feedback. These associations also play an important role in defining and monitoring professional ethics, another aspect of professional self-regulation which depends upon confidentiality.

hours of time and attention to this function, without any compensation whatsoever. These activities are performed in most cases by committees who meet early in the mornings, over the lunch hour, in the evenings, or on weekends as necessary to get the job done. It is detailed, demanding and often unpleasant work (e.g., when a physician's privileges to practice medicine in the hospital must be denied or restricted because the physician is unqualified or incompetent). In our litigious society, participation in the quality assurance/peer review process is fraught with legal peril as well. Statutory encouragement and protection of medical staff peer review has rightly followed.

D. The Quality of Emergency Medicine in This Country Will Suffer if Peer Review Records Can Be Obtained in Any Malpractice Claim filed as a Federal EMTALA Case.

Emergency medicine in many states constitutes the critical "safety net" for indigent patients as well as the working poor.[7] Peer review in this very difficult medical specialty is essential to maintain high quality medical services. Emergency physicians will be much less likely to engage in meaningful peer review activities knowing

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[7] Medicaid Access Group, *Access of Medicaid Recipients to Outpatient Care*, 330 New Eng. J. Med. 1426, 1430 (1994) (noting that many poor people have nowhere else to go other than hospital emergency departments); Robert S. Stern et al., *The Emergency Department as a Pathway to Admission for Poor and High-Cost Patients*, 266 JAMA 2238, 2238 (1992) ("Patients with lower socioeconomic status are more likely than other patients to use the emergency department as their means of access to the hospital.").

that a bad outcome in a case requiring review may also serve as the basis for a later malpractice case denominated as an EMTALA violation, in which their peer review efforts may be used against their hospital and peers, and about which they themselves may be deposed or called to the witness stand.

Nor are emergency medicine physicians the only ones who work in the emergency department. In the instant case, Dr. Schug is a family practice physician who works in the emergency room. Many specialties of physicians work in the emergency department, either covering emergency department shifts or serving "on-call" to the emergency department and responding to an emergency physician's request for help on a complex case. *Amici* have noted an increased difficulty in maintaining on-call specialty physician back-up panels in this country due primarily to poor or no compensation from either the patients or the managed care companies involved. An additional blow to the confidentiality of peer review records and information by permitting plaintiffs access through the "back door" of federal EMTALA claims can only further reduce the willingness of *all* physicians to serve "on-call" in emergency departments around the country.

As evidenced by the participation of *amici* representing a broad swath of the health care community, this case is of great national importance. For the foregoing reasons, as well as the reasons outlined in Dr. Schug's Petition for Writ of Certiorari, *amici* strenuously support the Petition in this case so the Court can make a reasoned judgment regarding the creation of a federal medical peer review privilege applicable in civil actions such as this or, in the

alternative, the application in federal court of state statutes protecting medical peer review information from discovery as a matter of comity.

Respectfully submitted,

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(5)

Supreme Court, U.S.
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No. 98-1526

In The

Supreme Court of the United States

WOLFGANG SCHUG, M.D.,

Petitioner,

vs.

DAVID BURROWS, successor-in-interest to Cody Burrows, deceased; DAVID BURROWS and RHODA THOMAS individually and as heirs and surviving parents of Cody Burrows,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITIONER WOLFGANG SCHUG, M.D.'S REPLY TO RESPONDENTS' CONSOLIDATED BRIEF IN OPPOSITION TO BOTH PETITIONS FOR WRITS OF CERTIORARI

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I. Respondents Concede That The Question of A Federally Recognized Peer Review Privilege Is Important And A Source Of Conflict Among The Federal Courts.

Petitioner Wolfgang Schug, M.D. has been joined by the medical profession, the hospital industry, the national accrediting body for hospitals and health organizations, and liability carriers for these industries in asking this Court to review the issue of whether a medical peer review privilege exists in federal courts. Respondents concede that the question of a federally recognized peer review privilege is both important[1] and a source of conflict in the federal courts.[2] Inasmuch as the presentation of a question of national importance and a conflict in the law are the touchstones for review (*see, e.g., Jaffee v. Redmond*, 518 U.S. 1, 7-8 (1996)), certiorari should be granted in this case.

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[1] Respondents state that the questions presented in the petition "might otherwise be interesting questions of privilege law" and are "of *potentially* significant legal interest." (Respondents' Brief, p. 1) (italics in original).

[2] Respondents concede there is an "apparent division of authority" in the federal court system over the medical peer review privilege. (Respondents' Brief, p. 11). Indeed, Respondents posit that the law is in such conflict that the District Court's discovery order could not have possibly been an abuse of discretion. (Respondents' Brief, p. 8). Respondents' position is that no district court in the United States could be wrong on this issue, no matter how it rules, because the law is in such disarray. The Court might wish, instead, to draw the conclusion from this argument that federal courts need Supreme Court guidance on the issue of a medical peer review privilege.

II. This Case Is Now Appropriate For Supreme Court Review.

Despite Respondents' concerns about the interlocutory posture of this case, arising as it does from a discovery order, the issues raised herein merit *immediate* review. **Indeed, the issue of California's peer review privilege can be reviewed only at the discovery stage because "[b]y its terms, Evidence Code section 1157 creates only a privilege against discovery from medical staff committees; it does not create a bar against introduction of evidence."** *Alexander v. Superior Court*, 5 Cal.4th 1218, 1223 n.4, 859 P.2d 96, 23 Cal.Rptr.2d 397 (1993). Therefore, the issue of medical peer review privilege would not come up at trial and could only arise in a discovery setting under Evidence Code § 1157. In general, questions of privilege arise in the discovery phase of a case, and this has not previously inhibited Supreme Court review of privilege issues.[3]

This case provides a particularly good vehicle for defining a medical peer review privilege in federal courts. Contrary to Respondents' argument, the District Court's rejection of the state peer review privilege was

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[3] *Cf., University of Pennsylvania v. Equal Employment Opportunity Commission*, 493 U.S. 182 (1990) (peer review privilege invoked in response to E.E.O.C. subpoena); *Commodity Futures Trading Commission v. Weintraub*, 471 U.S. 343 (1985) (attorney-client privilege asserted in response to subpoena duces tecum; certiorari granted to resolve circuit conflict); *Upjohn Co. v. United States*, 449 U.S. 383 (1980) (attorney-client privilege asserted in response to summons issued by Internal Revenue Service).

necessary for the District Court to reach its decision.[4] In its opinion, the District Court did not apply the doctrine of comity, nor did it have access to a clear and consistent body of federal law. Instead, it analogized this fundamentally medical malpractice case to an antitrust or employment discrimination case simply because plaintiffs alleged "spoliation of evidence" – a cause of action which was subsequently abolished by the California Supreme Court.[5]

Some federal courts recognize the peer review privilege in medical malpractice cases (*see, e.g., Bredice v. Doctors Hospital, Inc.*, 50 F.R.D. 249 (D.D.C. 1970), *aff'd*, 479 F.2d 920 (D.C. Cir. 1973)), but not in other contexts, *e.g.*, when doctors themselves attack the peer review process. *See Purgess v. Sharrock*, 33 F.3d 134 (2d Cir. 1994); *Memorial Hosp. v. Shadur*, 664 F.2d 1058 (7th Cir. 1981). Not all federal courts, however, draw this distinction. The Supreme Court has yet to offer its opinion on the topic.

A "mixed" case such as this – which is fundamentally a medical malpractice claim, but also involves an allegation that the peer review process itself was tainted – provides a perfect opportunity for the Court to opine whether, and under what circumstances, federal courts

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[4] Petitioner Wolfgang Schug, M.D. has only state claims pending against him. If this Court finds that he should be permitted to enforce the medical peer review privilege under Federal Rule of Evidence 501, then the proper disposition would be to grant his petition and summarily review the decision below.

[5] *Cedars-Sinai Med. Ctr. v. Superior Court (Bowyer)*, 18 Cal. 4th 1, 954 P.2d 511, 74 Cal.Rptr.2d 248 (1998).

should recognize state law peer review privileges and their exceptions, or create a federal medical peer review privilege with exceptions defined by the Court in its Opinion.

The *Perlman*[6] issue deserves certiorari on its own merits. Respondents' brief tries in vain to harmonize the law but cannot.[7] The *Perlman* exception to the one-judgment rule is a critical protection for persons such as Dr. Schug to protect against invasion of their rights by granting direct appeals when a district court has failed to apply a crucial privilege. Whether the hospital is motivated to protect his rights or not, Dr. Schug should be entitled to appeal the ruling against him. He should not be forced to rely on the motivation of a third party to protect the privilege as to him. The rationale of *Perlman* applies with equal force to the facts of this case.

Contrary to Respondents' argument, the issue before the Court is not whether the Ninth Circuit did or did not commit clear error in granting or denying Petitioner's writ of mandate. The Court may grant certiorari following summary denial of a petition for writ of mandate. *E.g., Hetzel v. Prince William County, VA*, 523 U.S. 208 (1998). As Chief Justice Vinson noted 50 years ago: "The

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[6] *Perlman v. United States*, 247 U.S. 7 (1918).

[7] Respondents assert that Dr. Schug's direct appeal has delayed prosecution of this case. Since the filing of Dr. Schug's petition in this Court, however, Respondents have filed a motion in the lower court invoking the pendency of Dr. Schug's current appeal and the stay of mandate to try to set aside recent rulings made by the District Court that are unfavorable to Respondents.

Supreme Court is not, and never has been, primarily concerned with the correction of errors in lower court decisions."[8] Rather, the Court, as a matter of judicial discretion, may grant review to answer important questions of federal law or to resolve conflict among the courts of appeal. SUP. CT. R. 10. As Respondents have conceded, those two criteria have been satisfied in this case.

Respectfully submitted,

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[8] Address of Chief Justice Vinson before American Bar Association, Sept. 7, 1949, 69 S. Ct. v, vi.